Psychiatry

Version 5.3

Corrected, Updated, Lighter

PLAB 1 Keys is for PLAB-1 and UKMLA-AKT (Based on the New MLA Content-Map)

With the Most Recent Recalls and the UK Guidelines

ATTENTION: This file will be updated online on our website frequently!

(example: Version 2.4 is more recent than Version 2.3, and so on)

Key 1

Important Forms of Delusion

Delusion of Reference

A false belief that insignificant remarks, events, persons, or objects in one's environment have personal meaning.

Examples,

- A person thinks that a TV show presenter/ female newscaster is directly communicating to him when she looks at the camera and when she says some words.

◙ A person thinks that someone constantly gives him special messages through the newspaper.

◙ A person believes that another person on the billboard outside his window is sending messages that are meant specifically for him.

Delusion of Control

A false belief that another person or group of people or external force controls his actions, thought, behaviour, feelings, or impulses.

Examples,

◙ A man says that his friend had made his own right arm to swing out to hit a stranger. His friend was at home.

Delusion of Guilt

Feeling guilty or remorseful for no valid reason (for something that a person has not committed).

Examples,

◙ I am responsible for the war/ hurricane/ floods that occurred in the city or in another country and thus I need to be punished!

Grandeur Delusion = (Delusion of Grandiosity)

A person he/ she is famous, powerful, wealthy, have exceptional abilities and talents, and keep praising themselves.

Examples,

A person thinks he is powerful and helps the prime minister.
A person thinks he will become a king or god later in life.

Persecutory Delusion

One believes that he is treated with malicious intent, hostility "unfriendly way", or harassment.

Examples,

They hate me, they meant to spy on me, they are plotting to harm me, they are following me to harm me.

Key 2

Psychological Conditions related to [Unexplained Symptoms]

There are a wide variety of psychiatric terms for patients who have symptoms for which no organic cause can be found:

Somatisation disorder

√ Multiple physical SYMPTOMS

"SoMatisation = So Many symptoms and investigations with no physical cause"

√ Patient refuses to accept reassurance or negative test results.

Examples,

A 30 YO ♀ complains of abdominal pain, headache, shortness of breath, unsteadiness, palpitations, and numbness of lower limbs for several months. ECG, X ray, Neurological examinations, and abdominal ultrasounds show normal findings.
→ Somatisation disorder.

Hypochondrial disorder (Hypochondriasis)

Persistent belief in the presence of an underlying SERIOUS DISEASE, e.g. Cancer, HIV

Hypo=under → underlying SERIOUS DISEASE.

Patient again refuses to accept reassurance or negative test results

Examples,

- **A woman persists that she has pancreatic cancer just like her dead husband.**
- **A woman persists that she has HIV despite several negative screening tests.**
- **A person believes that his benign lump is a cancer despite all reassuring investigations.**
- **A minor headache is caused by a brain tumour.**
- **Tiredness is caused by HIV.**
- **A mild rash is the start of skin cancer.**

Munchausen's syndrome = Factitious disorder

The intentional production/ falsification/ fabrication of physical or psychological signs and symptoms mostly to obtain medical attention and treatment.

Example,

◙ A woman always presents to the hospital complaining of abdominal pain and bloody stools. She brings a stool sample from home and is never able to produce a stool sample at hospital. Her stool samples and urinalysis are normal. This is the third time in the same month she visits the hospital. Her abdomen shows multiple scars of laparoscopies. She insists on getting more investigations although no abnormalities are found.

→ **Munchausen's syndrome**

(She is likely to be **intentionally** inserting blood into her stools at home to seek medical attention. Previous laparoscopies are done looking for the cause of her symptoms and abdominal pain but none has been found. **She still insists on more medical attention! She has abdominal pain but as doctors cannot discover the cause, she is fabricating signs "putting blood her stools" so they can care more**).

Malingering

Fraudulent simulation or exaggeration of symptoms with the intention of financial or other gain. (e.g. for compensations, to avoid military service, to obtain an opiate prescription).

Conversion "Dissociative" disorder

√ Typically involves **loss of motor or sensory function without organic cause.**
Dissociative = Sensory loss "and or motor"
√ The patient doesn't consciously -intentionally- feign "fabricate" the symptoms (factitious disorder) or seek material gain (malingering)
√ Patients may be indifferent to their apparent disorder – la belle indifference -.

Examples,

◙ **A 30 YO female is brought to hospital with limbs paralysis that developed after she has witnessed a card accident. She cannot remember what happened.**
→ **Conversion disorder** (loss of **motor/ sensory** function) without organic basis.

◙ **A 29 YO female witnessed a tragic car accident in which a boy had died. She could not sleep remembering the event. The following morning, she woke up unable to see. She has no previous medical or psychological history.**
→ **Conversion disorder** (loss of **motor/ sensory** function) without organic basis.

Ganser Syndrome

√ **A person deliberately and consciously acts as if he or she has a physical or mental illness** when he or she is not really sick.
√ People with Ganser syndrome mimic behaviour that is typical of a **mental illness**, such as schizophrenia.
√ Ganser syndrome is sometimes called "**Prison Psychosis**" because it was first observed in prisoners.

	(remember: **Ganser = Gangster "prisoners"** who claims **mental illness** to get a parole – release -). ***Examples,*** **A prisoner was taken to hospital. He complains of hallucination. When he is asked questions, he provides wrong answers but in the correct category. E.g. when asked who is the prime minister of England, he answers "Bill Clinton".** **→ Ganser Syndrome.**
Key 3	**Cotard's delusion = (Nihilistic delusion)** • The affected person holds the delusional belief that **they are already dead**, **do not exist**, are putrefying, or **have lost their blood or internal organs**. Also, the world has ended, nothing matters anymore, and any effort is pointless. • It is seen in **psychotic depression** and **schizophrenia** patients.

Note that it is not always about thinking of being "dead".

Example (1),

A man thinks that he does not have bowel and limbs and no one cares about it. → **Nihilistic Delusions**. Another name → Cotard's delusion.

It is seen in **psychotic depression** and **schizophrenia**.

Example (2),

A man believes that he is already dead and smells likely a rotten meat. He also lacks interest in life, daily activities and social interaction. He refuses to eat or

drink. He has no history of mental diseases. He lives alone and do not go out his home. Of the following, what is the most likely diagnosis?
[Schizophrenia – Depression – somatoform disorder].

This patient shows:

Nihilistic delusion (He believes that he is dead) +
Depression features (lack interest in life, social interaction, food, …etc)

→ Psychotic depression.

Of the given options, the most accurate answer → Depression.

Although **nihilistic delusion** can be seen in **psychotic depression** and **schizophrenia**, the other given features are more in line with depression.

Key 4

Delusional Misidentification

Capgras Syndrome

People who experience this syndrome will have an irrational belief that **someone they know or recognize has been replaced by an imposter "pretender"**. They may, for example, accuse a spouse of being an imposter of their actual spouse.

Example → "**You look identical to my husband but you are not him** "**!**

Example → "**A Young man is not allowing his father to enter the house as he thinks he is replaced by an identical looking imposter** "**!**

Fregoli delusion

A person holds a delusional belief that different people (more than one) are in fact a single person who changes appearance or is in disguise (Masked).

Example → "**A Young man thinks that every old man he meets is actually his father even though they look different but he is sure that they are his father but wearing a different disguise** "**!**

♣ You look like him and pretend you are him but you are fake (not him)
→ **Capgras**

♣ These 2 people are one person but changes his appearance
→ **Fregoli**

Key 5

Important Scenarios and Medications Related to Alcohol-Cessation

√ An alcoholic wants a medication to help reduce **withdrawal** symptoms
→ **Chlordiazepoxide**.

√ Acute alcohol **withdrawal symptoms** (*sweating*, *agitations*, *tremors*, *altered mentation*) → **Chlordiazepoxide "First"** + then give **Thiamine (Vit. B1)**

√ If with "**seizure" or "Hallucination"** [i.e., Delirium Tremens]
→ **IV Lorazepam**. Or **Diazepam** "If IV Lorazepam is not in the options) √.

√ Wernicke's encephalopathy (**CAS**: **C**onfusion, **A**taxia, **S**quint: ophthalmoplegia, Nystagmus, diplopia),
→ **IV Vitamin B1** = (**Thiamine**) = (**IV Pabrinex**) = (**High potency Vitamin B Complex**).

√ An alcoholic wants a medication to serve as a **Deterrent** when he takes alcohol "Abstinence" → **Disulfiram**.

√ An alcoholic wants a medication to reduce his **Craving** for alcohol → **Acamprosate**.

Example 1,
3 days post-hernioplasty, a 55 YO patient has become agitated, aggressive, confused and developed auditory hallucination.
Hb (normal), MCV 112 (high), Gamma-GT (high), ALP (normal).

The most appropriate management → **Lorazepam**.

√ Although this stem does not mention a Hx of chronic alcoholism, we can spot this from the raised MCV and GGT.

Note, in a stem with post-operative patient develops confusion, aggressiveness, suspect → **Chronic alcohol consumption**.

√ Since the patient has **NOT** been drinking for 3 days, he developed **Delirium tremens** (**Hallucination** is the clincher).

√ If the symptom developed in 6-24 hours after the surgery and there was **no** hallucination or seizures, it would only be "**Acute Withdrawal Symptoms**" such as ***sweating***, ***tachycardia***, ***anxiety***, ***tremors***. We would give → **Chlordiazepoxide** in this case.

√ If **CAS** (**C**onfusion, **A**taxia, **S**quint: ophthalmoplegia/ Diplopia), this would be **Wernicke's encephalopathy**. We would give

→ **Thiamine (Vit B1)**

Example 2

On the fourth day post-operative day, a woman has become confused and she sees spiders on her bed.

The likely Dx → **Delirium tremens**

(She is likely a **chronic alcoholic** and now develops **hallucinations** -seeing spiders- which indicate **delirium tremens** for which **IV Lorazepam** is used)

Key 6

Anorexia Nervosa	Bulimia Nervosa
◙ Significant Weight Loss due to self-food restrictions, excessive exercise, self-induced vomiting, laxative/ diuretics misuse. ◙ **Intense drive for thinness** (the patient always seeks to become thin and terrified of being obese) √ **Thickened calluses can be found on the back of hands (due to induced vomiting).**	◙ Repeated episodes of uncontrolled overeating (binge eating) followed by feeling guilty and thus compensatory mechanisms for weight loss (eg, fasting, excessive exercise, self-induced vomiting, laxative/ diuretics misuse) **Excessive eating** → **Guilt** → **Weight loss mechanisms** ◙ O/E: some features may be found: √ **Parotid swelling** √ **Thickened calluses** on hand dorsum (due to hand injury during self-induced vomiting)
BMI **< 17.5** kg/m^2	BMI is usually **> 17.5** kg/m^2

Management of Anorexia Nervosa

◙ **If BMI < 15, rapid weight loss**
+ evidence of system or organ failure or
(Medical complications eg, electrolyte disturbance, severe dehydration and malnutrition)
→ **Refer urgently to be admitted in Medical ward/ Paediatric ward** (patient needs to be admitted, treated and stabilised first!).
• **If she refuses admission**
→ Temporary admission under mental health act (section 5).
"This act allows doctors to detain -keep- patients in hospitals for 72 hours during which time they can perform assessment to see further keeping is necessary or not under mental health act".

◙ **If severe electrolyte imbalance, bradycardia, hypoglycemia**
→ **Admit to acute medical ward regardless of the BMI.**
• **If she refuses admission**
→ Temporary admission under mental health act.

◙ **If BMI < 15 but WITHOUT medical complications**
→ **Refer urgently to eating disorder unit** (no medical complications. Thus, nothing to be treated in the medical ward. The patient needs to eat as their BMI is very low, so refer to eating disorder unit).

◙ **If BMI 15-17.5, and No evidence of system failure or medical complications**
→ **Refer routinely to eating disorder unit (EDU) or to the local community mental health team.**

◙ **If severe self-harm, high risk of suicide**
→ **Amit to an acute psychiatric ward.**

◙ **If BMI > 17.5 (mild anorexia) WITHOUT complications**
→ **Build a trusting relationship with the patient, encourage the patient to use self-help books and a food diary.**

◙ **If BMI < 17.5 and > 15 and she insists that she has to lose more weight:**
→ **Refer to psychiatry.**

Try to follow your common sense and logic to absorb these lines for the exam.

Examples,

1 ◙ 19 YO ♀, BMI 12.5, has reduced her food intake for a few months, No menstruation for 1 year, **BP 70/50**, **HR 46**

→ **Admit to Medical ward**.

2 ◙ 21 YO ♀, has obsessive thinking that she is overweight, Her BMI is 17, She abuses laxatives and heavily exercises, her BP is 90/60.

→ **Refer to eating disorder unit**

(If SBP < 90 → Medical ward)

3 ◙ 16 YO female is brought by her mother after she has fallen down while in a shopping mall but recovered fully in less than a minute. The mother says that her daughter did not eat anything for 4 days because she is adamant that she is obese and needs to lose weight. The girl is sweaty and her blood glucose is 2.4. Her BMI is 18. The girl refuses to be admitted. What should be done?

→ **Compulsory admission to the medical ward.**

♦ Although her BMI is not very low, she has **hypoglycemia** and loss of consciousness which prompts an urgent admission as hypoglycemia might be fatal if not corrected. Remember, blood glucose of **< 4** is considered hypoglycemia. Other features of hypoglycemia include ***sweating***, ***tachycardia***, ***confusion***.

♦ Seeking legal advice is inappropriate because of the **urgency of the situation**. Hypoglycemia might be fatal if left uncorrected.

♦ As she refuses a voluntary admission despite her serious complication, she is likely lacking insight and thus needs to be compulsorily admitted under the Mental Health Act).

Remember,

If severe electrolyte imbalance, bradycardia, hypoglycemia

→ **Admit to acute medical ward regardless of the BMI.**

4 ◙ 19 YO ♀, BMI 21, thinks that she is obese. She eats uncontrollably and then feels guilty and thus performs self-inducing vomiting and heavy exercises.

The likely Dx → **Bulimia Nervosa**. "**Classic case**"

5 ◙ 18 YO ♀, BMI is 17.8, has bilateral parotid swelling, and thickened calluses on the dorsum of her hands.

The likely Dx → **Bulimia Nervosa**. "**BMI > 17.5 + Parotid swelling**"

6 ◙ 19 YO ♀, has obsessive thinking that she is overweight, Her BMI is 14.5, She abuses laxatives and heavily exercises, her BP is 95/70 and HR is 70.

→ **Refer urgently to eating disorder unit** (nothing to treat in the medical ward as no medical complications; the patient needs to eat as their BMI is very low).

7 ◙ 20 YO ♀, has obsessive thinking that she is overweight, Her BMI is 14.5, She abuses laxatives and heavily exercises, her BP is 95/70 and HR is 70. Her serum sodium and potassium are low. She has calluses on the back of her hands. She refuses admission under any circumstances.

→ **Temporary admission under mental health act** (section 5).

"This act allows doctors to detain -keep- patients in hospitals for 72 hours during which time they can perform assessment to see further keeping is necessary or not under mental health act".

Key 7

Autism Spectrum Disorder

♦ Global impairment of language and **communication.**
♦ Impairment of social **relationships.**
♦ **Compulsive** behaviour and **excessive mood swings**.
♦ **Collecting things** (eg, a boy has > 2000 car toys).
♦ **Repetitive behaviours or interests** (eg, repeatedly building lego, or do puzzles).
♦ **Most** children have a **decreased IQ** – the 'savant' is rare.
♦ Autism patients usually present when there is a **change** in their lives e.g., moving to a new school, death of someone they love.

Example 1,

A 15 YO boy, performs poorly in school since he moved to a new school, has very little social interactions and friends, prefers solitary activities, if disturbed, becomes very upset and anxious, likes collecting toys, has > 2000 toy cars.

→ ***Autism spectrum disorder.***

Example 2,

An 18 YO boy presents with these features: he finds it difficult to speak to others, speaks in flat tone, avoids eye contact with people, feels anxious around other people, dislikes physical contact, and he is being easily annoyed.
→ Autism spectrum disorder (in adulthood).

It is important to remember these features. This is not a case of social phobia; the boy in the stem shows features of anxiety more than fear.

Example 3

A 6-year-old girl presents with her mother with the following features: she does not make regular eye-contact with others. She prefers to stay alone and has struggled to make friends at school. Usually, she is reserved but can have noisy mood swings. She enjoys arranging her toys in one corner of her room and then moving them to the other corner. she does this repeatedly for hours a day. She is very selective with her food and she insists on the same food type every day. If she was given food she does not like, she would scream and get very upset.
→ Autism spectrum disorder (in adulthood).

Attention Deficit Hyperactivity Disorder ADHD

Diagnostic Features

Attention Deficit (inattention)	Hyperactivity/Impulsivity
Does not follow through on instructions	Unable to play quietly
Reluctant to engage in mentally-intense tasks	Talks excessively
Easily distracted	**Does not wait their turn easily**
Finds it difficult to sustain tasks	Will spontaneously leave their seat when expected to sit
Finds it difficult to organise tasks or activities	Is often 'on the go'
Often forgetful in daily activities	**Often interruptive or intrusive to others**
Often loses things necessary for tasks or activities	Will answer prematurely, before a question has been finished
Often does not seem to listen when spoken to directly	Will run and climb in situations where it is not appropriate

Example 1,

A 6 YO child is brought by his mother. She says that he is easily distracted, interrupts other students when it is their turn to answer questions. He is also careless, not able to do a task for a long time and is unable to play quietly.

The most likely Dx → attention deficit hyperactivity disorder (ADHD).

Q) If the child in the scenario above also has insomnia. What is the first line Rx?

→ First line: **Sleep Hygiene**. √

→ Second line: **Melatonin**.

Example 2,

An 8-year-old boy was brought in by his parents because of some behavioural problems. In an interview with his teacher, he described the boy as naughty, easily distracted and sometimes aggressive. His parents say that he has always had difficulty concentrating on tasks since infancy.

The most likely Dx → Attention deficit hyperactivity disorder (ADHD).

- **ADHD Symptoms**: Distractibility, forgetfulness, inability to complete tasks.

- **First-line Treatment of ADHD:**

→ **Methylphenidate** (which is a stimulant medication that helps improve attention and focus and reduces hyperactive and impulsive behavior).

Key 8

Mania	Hypomania
• Lasts **≥ 7** days • Causes severe functional impairment in social and work setting. • May require hospitalization due to risk of harm to self or others • Present with **psychotic symptoms (Delusions/ Hallucination)**	• A lesser version of mania • Lasts for **< 7 days**, typically **3-4 days**. Can be high functioning and does not impair functional capacity in social or work setting • Unlikely to require hospitalization • **No** psychotic symptoms

The following features can be seen in both Mania and Hypomania

◘ Mood

√ predominately elevated
√ irritable

◘ Speech and thoughts

√ Pressure of Speech → Rapid and accelerated speech without any pause and ignores interruptions, barely even pauses to take enough breaths.
Can be seen in mania (and bipolar).
√ flight of ideas/ more talkative than usual
√ poor attention

◘ Behaviour

√ insomnia (Decreased need of sleep)
√ loss of inhibitions: sexual promiscuity, overspending, risk-taking
√ Reckless behaviour with no regard for consequences.
√ increased appetite

IMPORTANT,

◙ **The above features + Psychosis** (***Delusions*** / ***Grandiosity*** / or ***Hallucinations***)
→ **Mania**

◙ **The above features** WITHOUT **Psychosis** (No ***Delusions***/ ***Grandiosity***/ or ***Hallucinations***)
→ **Hypomania**

◙ **Mania** + **Depression** (alternating)

→ **Bipolar affective disorder**.

Rx of bipolar→ **Mood stabilisers** → **Lithium** (the best).
√ In alternating mood swings → **Mood stabilisers** need to be **continued** if they had been stopped.

Very Important:
If a patient presents to a **primary care (ie, a GP)** with mood swings: good moods alternating with depression over periods [ie, **bipolar affective disorder**]"
→ **Refer to psychiatry** (secondary care).
(**Mood stabilizers** eg, **lithium** should be prescribed by **psychiatric** team).

Example 1,
A 32 YO ♀ had depression a few years ago has recently spent a huge amount of money on buying new clothes and accessories. She goes out with friends almost every day. She believes she knows the best places that serve food and thus she does not allow any of her friends to choose a restaurant. She sleeps less than usual and tends to fill her day with numerous activities.
The patient had (**Depression**), Then developed (**Mania**)
So, the Dx → **Bipolar affective disorder**.

Very Important:
If a patient presents to a **primary care (ie, a GP)** with mood swings: good moods alternating with depression over periods [ie, **bipolar affective disorder**]"
→ **Refer to psychiatry** (secondary care).
(**Mood stabilizers** eg, **lithium** should be prescribed by **psychiatric** team).
√ Note that time gap does not matter.

√ Mania here → Grandiosity (she thinks she knows the best places to eat).
√ The rest features can be seen in Mania and Hypomania. However, since there is delusion of grandiosity, it is MANIA.
√ Mania alternating with Depression → Bipolar.

Some students think that "**Hypomania**" is closer to "**depression**" because of the prefix "**hypo**". **This is WRONG**! **Hypomania is a lesser form of mania**. The main differences are that **mania lasts longer (> 7 days)** and often has additional **psychotic symptoms** such as delusions and hallucinations.

Example 2,

A 33 YO woman has recently become more active, sleeps less, ↑ sexual drive, bought a new car and a house, doing multiple tasks simultaneously and thus do not finish them.

The likely Dx → **Hypomania**

(DO NOT PICK MANIA unless there are associated psychotic features such as grandiosity, delusions, hallucinations ± lasting for > 7 days)

Hypomania is a mild form of mania.

Low moods → Depression
Low mood + High mood (alternating) → Bipolar
High mood only → Hypomania
High mood + Psychotic (eg, delusions, hallucinations) → Mania

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Example 3,

A 32 YO ♀ has recently started to suffer from low moods, poor eating and insomnia. She prefers to stay at home and refuses to go out with friends. She also lost 7 kg in the last 10 weeks. A year ago, she was full of energy, optimistic and needed very little sleep.

The patient had (**Mania/ hypomania**), Then developed (**Depression**)
So, the Dx → **Bipolar affective disorder**.

Example 4,

A 36-year-old is working around in the GP surgery and is threatening patients. He is verbally abusing them by saying they are crazy people as they use the medical system abusively and frequently. He strongly believes that he can manage and run the medical system better than the local authority. He speaks quickly and cannot be interrupted. He has not sleep for 3 days thinking about ideas and solutions so serve the local medical system. There is no history of previous psychiatric illnesses. What is the most likely diagnosis?

→ **Mania**.

What is seen in this scenario?

√ Elevated moods (Screaming, greatly exaggerating ideas and plans) and insomnia (did not sleep for 3 days) and pressure of speech (speaking quickly un-interrupted) are all seen in **mania** and **hypomania**.

	√ **However**, since he additionally has features of **psychosis** (delusions /grandiosity) that he can serve the medical system better than the authorities. So → High moods + Psychosis → **Mania**.
Key 9	**Lithium** "IMPORTANT" ◙ Lithium is **mood stabilising** drug used most commonly in **bipolar disorder** but also as an adjunct in refractory depression. ◙ **Features of Lithium toxicity (Important)** √ **Coarse tremor** (a fine tremor is seen in therapeutic levels) √ **Muscular twitching, weakness** √ **Nausea** and **Vomiting** √ **Drowsiness**, **confusion** √ **Hyperreflexia** √ **Seizure** (in severe toxicity) √ **Coma** (in severe toxicity) √ **Blurred vision** √ **Tinnitus (ringing ear).** ◙ **Management (imp).** ♦ Stop lithium and take serum lithium levels.

If high → Amit the patient to the medical ward (& repeat levels each 6-12 hours).

♦ Mild-moderate toxicity may respond to resuscitation with normal saline.

♦ Haemodialysis may be needed in severe toxicity.

◙ If **lithium toxicity** developed (eg, blurry vision, tinnitus = ringing ears, dizziness, lethargy, muscle weakness, diarrhea, vomiting)

→ Stop lithium, take serum lithium level → admit to medical ward, and repeat serum lithium level every 6-12 hours + Supportive care (There is **no antidote** to lithium toxicity).

When toxicity resolves, lithium can be restarted at a lower dose (Never stop lithium suddenly; it has to be gradually over a period of 3 months to prevent relapse).

Example 1,

A 41-year-old presents to the ER with nausea, vomiting, muscle weakness, coarse tremors, blurred vision, dizziness and tinnitus. He is on lithium for his bipolar disorder and has recently increased the dose. His lithium level is found to be high. The last time he took his lithium tablet was 13 hours ago. His ECG is normal. His blood pressure is 130/80 mmHg. The doctor asked him to sop his lithium temporarily. What is the most appropriate action?

→ Amit him to the medical ward.

(For observation + for measurement of serum lithium levels every 6-12 hours).

Example 2,

A man with **bipolar disorder** for 10 years and knee pain for which he takes **ibuprofen** develops **tremors**, **vomiting** and **confusion** while travelling a long distance.

The most appropriate test to be done → **Serum Lithium concentration**.

Note, **Diuretics** and **NSAIDs** (e.g., Ibuprofen) increases renal reabsorption of lithium and hence, the **serum lithium increases** and may lead to toxicity.

◙ Lithium and ibuprofen interaction "important":

→ **↑ renal reabsorption of lithium** i.e., **↓ renal clearance of lithium**.

→ **↑ Risk of lithium Toxicity**.

Lithium + Pregnancy

♦ Lithium is **teratogenic** (risk of fetal cardiac malformations "Ebstein anomaly", thyroid disease, Floppy baby syndrome).

◙ **If a woman on lithium is planning to get pregnant**

→ **Reduce Lithium Gradually and Stop it before pregnancy is confirmed**.

◙ **If a woman on lithium becomes pregnant**

→ **Consider stopping lithium gradually over 4 weeks if she is well**.

◙ **If a woman takes lithium while she is pregnant**

√ **Check plasma lithium levels Monthly till the 36 weeks of pregnancy**, then

√ **Check plasma lithium levels Weekly till birth**.

Lithium levels are checked **1 week** after initiating lithium.

After that, lithium levels are checked **every 3 months** while Liver Function Tests and Urea and Electrolytes are checked **every 6 months**.

√ **Important**, **Check lithium levels 12 hours after taking the last lithium dose** (as it has a narrow therapeutic range).

Remember,

Diuretics and **NSAIDs** can lead to **↑ serum lithium levels**.

A bipolar patient on lithium was found to have high serum lithium levels and hypokalemia. He has recently started an antihypertensive medication. What is this medication?

√ The **diuretic** that is used as an **antihypertensive** and can cause **hypokalemia** is → **Thiazide like Diuretic (Bendroflumethiazide)**.

√ Diuretics can also ↑ lithium levels.

♦ Remember, ACE inhibitors can cause HypeRkalemia.

The 2 most important tests to be done before initiating lithium are:

♣ Thyroid Function Tests. √

♣ Kidney Function Tests. √

√ **Remember, not to be confused:**

Before prescribing **amiodarone**

	→ **Serum Electrolytes and Urea measurements should be obtained**. --- **Important**, In a **bipolar** patient who is on Lithium, an **addition of a SSRI** (such as Sertraline, Fluoxetine) can **worsen the episodes of Mania**. Therefore, **it should be stopped** if mania is worsened. ***(Antidepressants precipitate Manic episodes)***
Key 10	**A woman has depression since her husband died 6 months ago.** **She is on Amitriptyline (TCA) for 3 months now and she feels better.** **She would like to stop the medication. What is your advice?** √ Antidepressants are not addictive. √ For fear of relapse, it is advised that antidepressants are continued for **at least 6 months in total even if there is improvement** as in this case. √ So, the advice would be → **Continue amitriptyline for another 3 months**. **A woman with depression after the death of her husband has completed 6 months of SSRI and thus, she stopped taking her medication. After a while, she develops a feeling that she has pancreatic cancer just like her dead husband.** The likely Dx → **Hypochondriacal delusion**. The next step → **Neuropsychiatric analysis**.

Hypochondrial disorder

Persistent belief of the presence of an underlying SERIOUS DISEASE, e.g. cancer, HIV

Hypo=under → underlying SERIOUS DISEASE.

Patient again refuses to accept reassurance or negative test results

Key 11

Depression

Depression Typical Features.

√ Low Mood.

√ Lack of Energy.

√ Loss of interest to do daily activities.

√ Insomnia "inability to sleep" "sleeps less than usual".

√ Anorexia "loss of appetite".

√ Weigh Loss.

√ Difficulty in concentrating.

√ Avoid eye contact

Depression can be described as → **Low Mood**.

Important,

Sleeps a lot, eats a lot, ↑ weight → Atypical Depression "but still depression".

Example, A woman with low mood but sleeps a lot and has an increased appetite and ↑ in her weight.

→ **Atypical Depression** (in Typical depression, there would be ↓ sleep and eating).

◙ First line Rx of **Depression**

→ **Cognitive behavioural therapy (CBT)**. Followed by "counselling".

CBT focuses more on changing patient's patterns of thinking, emotions and behaviour. Counselling is less directive and involves more listening, empathy and encouragement. Patients who fail to respond to CBT are referred for counselling.

◙ If **medications** needed (eg, CBT failed, significant depression), start with:

→ **SSRIs "Selective Serotonin Reuptake Inhibitors"**. "It takes 2-4 weeks to work"

Remember the Steps of Depression Management:

♦ **Start with "Psychotherapy" by a "Psychologist" before medications (e.g., Cognitive behavioural therapy CBT)** *especially in mild to moderate depression*.

♦ **Start with SSRIs (eg, Fluoxetine, Sertraline, Citalopram…).** *SSRIs are considered first-line pharmacological treatment for moderate to severe depression*.

[**Important**: If depression is severe, especially with thoughts of self-harm,

→ **SSRIs (e.g., sertraline)** are typically the first-line treatment. In practice, antidepressants are often prescribed alongside a referral for Cognitive Behavioural Therapy (CBT) to provide a more holistic approach].

♦ **No response in 2-4 weeks? → Check patient's adherence to the medication.**

♦ **Patient is adherent but still no response after 4 weeks of use. What's next?**

→ **Either ↑ the dose of SSRI OR Shift to a different SSRI OR shift to a different class of antidepressants (eg, Mirtazapine, which is a tetracyclic antidepressant - presynaptic alpha 2 antagonist-).**

Important Points on Choosing the Appropriate Antidepressant:

• If no CBT or SSRIs in the options, pick a different class of antidepressant. For example, **Mirtazapine**, which is a tetracyclic antidepressant.

• If the patient is on **warfarin**, (ie, there is risk of bleeding), pick → **Mirtazapine**. (*This is because SSRI ↑ the risk of GI bleeding if taken with warfarin*).

• 2nd line after Mirtazapine if there is risk of bleeding → Sertraline.

• In patients with a history of cardiovascular disease, eg, **Myocardial Infarction (CAD), heart failure**, the first line SSRIs → **Sertraline**, followed by **Citalopram**. (*Sertraline has a better cardiovascular safety profile*).

• In **breastfeeding** women → **Sertraline**.

• Having orthostatic hypotension and/or benign prostatic hyperplasia **do not** contra-indicate the use of **SSRI as a first line** antidepressant. (*Previously asked*).

• The preferred antidepressant for **teenagers** (<18 years old) → **Fluoxetine**.

Fluoxetine is the only SSRI licensed for use in children and adolescents for depression in many guidelines.

(All of these points are important and asked frequently in the exam).

◙ **Important:** What if severe depression + Psychotic depression (ie, in additional to severe depression, there is hallucination e.g., hearing voices)

→ **Electroconvulsive therapy (ECT)**.

After the course ECT, the patient should be referred to cognitive behavioural therapy (CBT).

Example,

A 65 YO man has just suffered from myocardial infarction and is now to be discharged. He feels sad, avoids eye contact, and skipped his last 2 meals.

The likely Dx → **Depression**.

Rx → **Sertraline** (**The best SSRIs in MI patients is → Sertraline**).

If not in the options, pick (**Citalopram**) "the 2nd line SSRI in MI patients".

Examples of some drug families:

♦ **SSRIs** "Selective Serotonin Reuptake Inhibitors"

→ Citalopram, Fluoxetine, Sertraline, Paroxetine.

♦ **SNRIs** "Serotonin-Norepinephrine Reuptake Inhibitors"

→ Venlafaxine, Duloxetine.

♦ **TCA** "Tricyclic Antidepressants"

→ Amitriptyline.

♦ **Presynaptic alpha 2 antagonist (Atypical antidepressant)**

→ Mirtazapine

Depression + Psychosis "eg, hallucinations" → Psychotic depression

Example 1,

After the death of her husband 2 years ago, a 33 YO woman has lost interest in life and would sleep less than usual and eats a lot. She sometimes hears her husband's voice and feels guilty for his death.

→ **Psychotic depression**.

√ Once **hallucination/ delusion** is there, we play in the "**psychosis**" field.

√ Other points towards Psychosis → feeling guilty, delusion, hallucination.

√ "**Severe Depression**" would have **suicidal intent** "without psychosis". So, it is a wrong answer here.

Example 2,

A 68 YO ♀ thinks that she has died 6 months ago and is distressed that nobody has buried her yet. She sometimes hears voices telling her that she is evil and needs to be punished. She has past history of feeling guilty and personal inadequacy.

She thinks that she is dead → **Nihilistic delusions** (**Cotard's syndrome**).

√ Nihilistic delusion is seen in → **Psychotic depression**.

Example 3,

A 29 YO man was found in a park drunk and thus brought to the ED. He has recently lost his job and had a divorce 3 months ago. He feels he is worthless and that he is a failure. He sometimes hears voices telling him he is worthless.

→ **Psychotic depression**.

Feels worthless and a failure → **depression**.

Hears voices → hallucination → **psychosis**.

Reminder:

The first step in dealing with depression especially if mild-moderate:

→ **Refer to "Psychologist"** not "Psychiatrist" for **cognitive behavioural therapy**.

Example 4,

A girl has been feeling low since changing her school. She mises her friends at the old school. She stopped enjoying her best hobbies and activities. He suffers tearing at night and inability to sleep.

→ Refer her for **psychotherapy** as a first step before commencing medications.

Key 12

Post-partum mental health problems

'Baby-blues' "Post-partum Blue	**Postnatal depression**	**Puerperal psychosis (Post-partum Psychosis)**
√ Typically seen **3-7** days following birth and is more common in primiparous. √ Mothers are characteristically **anxious**, **tearful** and **irritable** ◙ Mothers **care** for baby. ◙ Mothers are mostly **Crying**	√ Peaks at 3 or 4 weeks postpartum but can occur anytime in the first 6 months. √ Features are similar to depression seen in other circumstances. ◙ Mothers care for baby but with occasional thoughts of harming baby. ◙ **Important examples**: • **She feels she cannot look after her baby and** • **She won't be a good mother**.	√ Begins at 2-4 days postpartum and peaks at 2 weeks. (Can present at any time after delivery) √ Features include severe swings in mood (similar to bipolar disorder) and disordered perception (eg, auditory hallucinations) ◙ **Important hints**: • Thoughts of harming baby. • Hearing voices saying baby is evil or has **evil eyes**. • Delusions that the baby is deformed or evil.

	• **Tearful, Anxiety**. • **Worries about baby's health**. • Worries about her ability to **cope with** her newborn.	• Insomnia and Disorientation. • Thoughts of Suicide.
♣ **Reassurance**, explanation and support.	**Rx → CBT, then SSRIs "if she is breastfeeding → Sertraline is the SSRI of choice"**	♣ Admission to hospital with a specialist mother-baby unit. ♣ **Electrocompulsive therapy (ECT)** ♣ Mood stabilisers. ♣ Antidepressants.

Example (1),

A woman has delivered a baby 6 weeks ago. She feels sad and has no interest to feed her baby. She eats poorly and has poor sleeps. She says that the baby has evil eyes.

√ The likely Dx → **Post-partum psychosis**.
√ Clues: baby has **evil eyes** – lacks caring for baby.

Example (2),

A woman has delivered a baby 3 days ago. She thinks that the midwife wants to harm her baby. She sometimes hears voices. She thinks that the nurses are plotting to steal her baby. Sometimes, she gets intrusive thoughts to harm her baby.

√ The likely Dx → **Post-partum psychosis**.
√ Clues: baby has **evil eyes** – lacks caring for baby – **Harming baby** – Delusions – Hallucinations.
√ Rx → Electroconvulsive Therapy (ECT)

Example (3),

A 34 YO woman has delivered a baby **3 days ago**. She has **anxiety**, irritability and poor sleeping. She is **crying all the time**.

The likely Dx → **baby-blues**.
The most appropriate management → **Reassurance**.

Example (4),

A 30 YO woman who gave birth 6 months ago presents to her GP complaining that she is crying all the time, not bonding with her baby. Worried about baby's health constantly, being unsure if she can cope with this new change in her life.

The likely Dx → **post-natal depression**.

Rx → **CBT**, then **SSRIs** "if she is **breastfeeding** → **Sertraline** is the SSRI of choice"

√ Remember, baby-blues are early after delivery (**3-7 days**).
√ "**Crying all the time**" is also an important feature **in baby-blue**.
However, **6 months** after delivery along with the other features make it Depression.
√ No features of Psychosis here (e.g. baby has evil eyes, delusions…).
√ The other features support postnatal depression (review the table above).

Key 13	After the death of his wife 6 months ago, a 55 YO man developed severe depression. He thinks there is no point in living anymore and refuses any help or treatment. What should be done? → **[Compulsory] Admission under Mental Health Act**. √ As **he refuses** any medical support, "**voluntary**" admission is **not** suitable. √ This law allows to admit people with mental disorders **compulsorily** "**against their well**" as long as there is risk either on themselves or on others. What if the stem did not mention that he refuses treatment? → **[Voluntary] admission to the psychiatric ward**. **Common reasons for hospital – Psychiatric ward admission:** √ Severe depression/ Psychosis. √ Serious risk of harm to self or others. √ Significant self-neglect. √ Lack of social supports. √ initiation of electroconvulsive therapy (ECT). √ Depression that is not responsive to home treatment.
Key 14	A 58 YO man is brought the GP surgery by his wife. He has a lump on his forehead and his wife wants this mass removed. However, he refuses and says that this growth helps him think better. What should be done NEXT? → **Assess his mental capacity to refuse treatment**.

	√ After that, if he is mentally capable (compos mentis), we should respect his wishes. √ **Note**, Mini Mental Status Examination (MMSE) is used to assess **dementia** to identify the areas of cognitive impairment.
Key 15	**Schizophrenia** ◙ The hormonal disturbance in Schizophrenia is → **dopamine**. Symptoms may be divided into **auditory hallucinations**, **thought disorders**, **passivity phenomena** and **delusional perceptions**: ◙ **Auditory hallucinations**: **First/ Second/ Third Person → Comment on one's action/ behaviour:** **Third-person auditory hallucination** (**important √**) Example → A voice is heard saying (**he**/**she**) narrating his action. "**He is evil**", "He is moving", "**She is turning on her phone**". "**He is getting up**. **Now, He is going towards the window**" **Second-person auditory hallucination** Example → A voice is heard saying (**You**). "You are evil", "You are moving", "You are opening your phone".

First-person auditory hallucination

Example → A voice is heard saying (**I am**). "I am lying down", "I am moving".

Thought Echo (echo de la pensée) → the patient has a hallucination of hearing aloud his or her own **thoughts** a **short time after** thinking them.

Gedankenlautwerden → the patients hear their own **thoughts** aloud **at the time** they think them.

◙ Thought disorder:

♦ **Thought insertion** → **A delusional belief that thoughts are being placed into the patient's head from outside.**

♦ **Thought withdrawal** → **A delusional belief that thoughts have been stolen (taken out) of his/ her mind.**

♦ **Thought broadcasting** → **A delusional belief that patient's thoughts are being accessible directly to others.**

♦ **Thought blocking** → **A sudden break in the chain of thoughts.** (eg, A person with his speech is interrupted with silence for a few seconds followed by speech in a different topic)

◙ Passivity phenomena:

Bodily sensations and actions being controlled by external influence.

◙ Delusional perceptions:

A two-stage process where firstly a **normal object is perceived** **then** secondly **there is a sudden intense delusional insight into the objects meaning** for the patient
[In other words, delusion of perception describes perception that attributes a false meaning].

Example 1: 'The traffic light is green therefore I am the King'.
√ **The traffic light is green** → **Ok, a normal object**. THEN:
√ → **So, I am the king** → !! **wrong perception of the object's meaning!**

Example 2: 'Every time a man sees his friend wearing a green shirt, he believes that aliens are coming to control his actions.
√ **His friend wears a green shirt** → **Ok, a normal thing**. THEN:
√ → **So, aliens are coming to control his actions** → !! **wrong perception of the object's meaning!**

◙ **Other features of schizophrenia**
• impaired insight
• incongruity (e.g., a person is talking about the death of a loved one while he is laughing)/blunting of affect (inappropriate emotion for circumstances)
• decreased speech
• neologisms: made-up words
• catatonia
• negative symptoms: incongruity/blunting of affect, anhedonia (inability to derive pleasure), alogia (poverty of speech), avolition (poor motivation)

A common type of schizophrenia to know is

→ **Catatonic Schizophrenia**.

It is characterized by the following:

√ Reduction in movement.
√ Rigid posture.
√ Not talking.
√ Sluggish response.
√ Staring for long period of time.

Management of Schizophrenia:

→ **Atypical antipsychotics e.g., Risperidone, Olanzapine**.

→ **2nd generation antipsychotic e.g., Quetiapine**.

Example 1,

A 30 YO man thinks that the nurses are plotting to harm him and they are stealing his ideas out of his mind. Sometimes, he feels that the nurses can control his body.

The likely Dx → **Schizophrenia**.

♦ Plotting to harm him → Persecutory delusion.
♦ Stealing his ideas → Thought withdrawal.
♦ Control his body → Passivity phenomena.

Example 2,

A 31 YO man always thinks that when the traffic light turns red, his mother is calling home to come home.

The likely Dx → **Schizophrenia**.

♦ This feature is called → Delusional Perceptions (one of the features of schizophrenia).

Example 3,

A 30 YO man is very annoyed with everyone around him. He complains that they put ideas into his head.

The likely phenomenon → **Thought insertion**.

Example 4,

A schizophrenic 31 YO woman says that her children can hear her thoughts and can know what she is thinking all the time.

The likely phenomenon → **Thought broadcasting**.

Example 5,

A 20 YO male hears voices telling him that he is being spied on. His speech is interrupted with silence for a few seconds followed by speech in a different topic. He feels he is no longer in control of his body and thoughts.

◙ The likely Dx → **Schizophrenia**.

◙ The most appropriate Rx

→ **Olanzapine or Risperidone (Atypical antipsychotics).**

√ His speech is interrupted with silence for a few seconds followed by speech in a different topic → **Thought blocking**.

√ He feels he is no longer in control of his body and thoughts

→ **Passivity Phenomenon**

Both are features of Schizophrenia.

Example 6,

A 29 YO lady has been suffering from intrusive thoughts. She believes that her neighbours are plotting against her. She is convinced that she hears them planning to burn her house. She has no suicidal thoughts. What medication is helpful to treat her symptoms?

[Lithium/ Lorazepam/ Fluoxetine/ Citalopram/ Quetiapine].

√ The only anti-psychotic given here is quetiapine (for treatment).

√ Lorazepam (short-acting benzodiazepine) is given if rapid tranquilization is needed.

Example 7,

A 26-year-old man present to the ER complaining of the following: He says that a microchip (electronic implant) was inserted in his brain a month ago by his neighbours so they can read his activities. He hears voices narrating his moves such as (now, he is walking, now he is going to bed, now he is going to the hospital). He feels that his actions are under external influence. He is desperately seeking a CT imaging of his head. He believes that his neighbours are aiming to attack him and disturb his life. He denies taking recreational drugs but he drinks an average of 24 units of alcohol a week. What is the most likely diagnosis?

A) Schizophrenia.

B) Delirium Tremens.

C) Dementia.

D) Drug-induced psychosis.

E) Hypomania.

Answer → A.

• This is most likely a case of **schizophrenia** as it demonstrates the following features:

√ Delusion → Delusional belief that a microchip has been inserted into his brain.

√ Third-person auditory hallucination: → A voice is heard saying (he/she) narrating his action. Eg, “Now, he is going to hospital”.

	√ Passivity phenomenon → He believes that he is under control of external influence. • The history of **alcohol** given here as a distractor. There is no mention of sudden alcohol cessation in the stem. **Delirium tremens** occurs after a sudden stop or reduction in chronic alcohol consumption. It presents with confusion, delusion, hallucination and may be seizure only a few days after alcohol cessation.
Key 16	◙ **Auditory hallucination while going to bed (falling asleep)** → **Hypnagogic Hallucination**. ◙ **Auditory hallucination while waking up** → **Hypnopompic Hallucination**. *The term hypnopompic describes the period when a person wakes up. Hypnagogic defines the period when a person falls asleep.* Hypna**GO**ic → While **Go**ing to bed. Hypno**POMP**ic → While **POMP**ing out of bed. ***Example,*** A 32 YO man hears his mother calling his name only when he is **about to fall asleep**. This makes him wake up to find no one in the room. → **Hypnagogic Hallucinations**.

Key 17

Panic Attacks

- Periods of intense fear characterised by: **palpitations**, **sweating**, **tremors**, **SOB** that develop **rapidly**.
- It peaks around **10 minutes** and then gradually settles and resolves over the next **20 minutes**.
- **Extreme**: a patient feels that he is **going to die** from cardiac or respiratory problems. (***sudden severe sharp stabbing chest pain may also occur mimicking MI but with normal ECG and examinations***)!
- **Usual**: **Dizziness**, **circumoral paraesthesia and tingling**, **carpopedal spasm** ± sharp or stabbing chest pain.
- Patients are usually **tachycardic** and **tachypnic**.
- **Hyperventilation → washout of CO2 → Respiratory Alkalosis → Hypocalcemia (Low ionic Ca^{++}) → Tingling**
- It is important to rule out the secondary causes of tachycardia, chest pain or SOB. Thus, investigations such as ECG, O2 Saturation, Blood glucose are important initial investigations.
- FBC, KFT, CXR are required if symptoms do not settle in a few minutes.
- **Management**:
- **General Rx to prevent further attacks → Cognitive Behavioural Therapy (CBT)**

  Or SSRIs (e.g. Sertraline, Fluoxetine…).
- **Acute episode → Simple breathing exercise such as breathing through nose, paper bag, slowing down breathing + Reassurance** is all that is needed.

Panic Disorder Management simplified:

√ Rx **before** attack (to help in an upcoming event) → **Propranolol** (Beta-blocker).

√ Rx **during** attack → **Rebreathe into a paper bag**.

√ **Long-term** Rx and to prevent further attacks

→ 1st: Psychological → **CBT**.

→ 2nd: Medical → **SSRIs**.

Generalised Anxiety Disorder (GAD)

Uncontrollable, long persisting feeling of anxiety, stress, palpitations, worrying about everyday events (e.g. money, expenses, children, job).

Other features (not always present):
Tachycardia, palpitations, thinking about everyday events, restlessness, irritability, muscle tension, sweating, breathing difficulties, chest discomfort, fear of losing control or going crazy.

Management

- Cognitive Behavioural Therapy (CBT)
- SSRIs → Sertraline "1st line SSRIs".

IMPORTANT
In **GAD**, the symptoms are **long-lasting** while **panic attacks** are **short** (10-30 minutes).

i.e., the symptoms in **GAD** are present nearly **all the time**, whereas the symptoms of **Panic disorder** are **Episodic**/ **Sudden**

"even if they occur every day, as long as they are sudden episodes, it is Panic Disorder".

Example (1),

A 40 YO ♀ presents complaining of sweating, palpitations, restlessness almost throughout the day for the last 1 year. She is irritable and has difficulty to concentrate. She thinks about every day events. She also has occasional chest discomfort and shortness of breath. She reports no triggering factors.

→ **Generalised Anxiety Disorder**.

Example (2),

A 29 YO ♀ feels anxious almost every day throughout the last 6 months. She feels distressed when thinking about money and her job. She has poor sleeps and poor concentration at work. Occasionally, she panics and feels that she is about to die. Her BP is 120/80 and HR is 88.

→ **Generalised Anxiety Disorder**.

Rx → **CBT**, **if not given**, pick **SSRIs**.

It is important to note that GAD is different from Social Phobia.

Social Phobia (Social Anxiety Disorder).

Patients try to avoid situations like "meetings", "Group events", "Public speaking", "eating in front of people" because they are afraid to be criticised or embarrassed. The symptoms are exaggerated.

Thus, in social anxiety disorder (social phobia):
√ There is a **tigger** (eg, being on a stage, meeting others, eating in front of others).
√ Patients fear to be [**Judged**] and or [**Observed**].

Remember that: **Panic attacks** occur out of the blue "ie, **no triggers**"

Example (1),

A 30 YO woman develops palpitations and dizziness whenever she is in a meeting. She always feels that her fellow workers are judging her. She tries to avoid meetings.

The likely Dx → **Social phobia (Social Anxiety Disorder).**

Rx → Like GAD: **Cognitive behavioural therapy**, **if not given**, pick **SSRIs**

Example 2,

A 40 YO woman is socially withdrawn, does not like to go out of the house, feels distressed whenever she eats in front of strangers, avoids business meetings because she fears that her colleagues would criticise her.

The likely Dx → **Social phobia (Social Anxiety Disorder).**

Key 18	**Grandeur Delusion = (Delusion of Grandiosity)** **A person he/ she is famous, powerful, wealthy, have exceptional abilities and talents, and keep praising themselves.** **Example**, A person thinks he is powerful and helps the prime minister. A person thinks he will become a king or god later in life. **Remember, Grandiosity is a form of → Delusion.**
Key 19	◙ **Othello Syndrome** → Over-jealousy "**suspecting unfaithful partner** like cheating/ adultery" and therefore may try to monitor their partners. ***OTHELLO*** *= Delusion that a partner says* ***HELLO*** *to* ***OTHERS*** *:-D* (Silly but memorisable) ◙ **Ekbom's Syndrome** → Delusion of Parasite infestation. (I am infested by parasites). ◙ **Capgras Syndrome** → People who experience this syndrome will have an irrational belief that someone they know or recognize has been **replaced** by an imposter "**pretender**". They may, for example, accuse a spouse of being an imposter of their actual spouse. Example → "You look identical to my husband but you are not him"! ◙ **Fregoli delusion** → A person holds a delusional belief that different people (**more than one**) are in fact a single person who **changes appearance** or is in disguise (**Masked**).

Key 20

Obsessive Compulsive Disorder (OCD)

Obsessions:

Persistent, unwanted, repetitive, intrusive thoughts, images, and urges which are ego-dystonic and cause anxiety and distress.

Compulsions:

Repetitive behaviours or mental acts performed in response to an obsession to reduce the anxiety or distress to prevent a feared consequence.

Examples

Obsessions	Compulsions
Fear of contamination	Cleaning or washing rituals
Pathological doubt	Repetitive checking
Sexual or Violent intrusive thoughts	Repetitive undoing thoughts
Fear of causing harm	Repeated checking
Need for symmetry and exactness	Ordering or arranging things
Religious obsessions	Religious rituals e.g. excessive praying
Superstitious obsessions	Superstitious rituals e.g. repeating activities a certain number of times

√ Checks the doors several times.
√ Turn the light on and off several times.
√ Washes his hands every time he touches the door lock.

First Line Rx → **Cognitive Behavioural Therapy (CBT)** "better than SSRIs".

Important: "Sometimes → **Exposure and Response Prevention (ERP)** is the right answer as it is a part of CBT"

Key 21

Post-Traumatic Stress Disorder

◘ Post-traumatic stress disorder (**PTSD**) can develop in people of any age following a traumatic event. For instance, a major disaster/ housefire/ childhood sexual abuse/ death of a loved one/ War.

◘ One of the diagnostic criteria is that symptoms have been **present for more than one month.**

◘ **Features**:

√ **Re-experiencing**:
flashbacks, nightmares, repetitive and distressing intrusive images

√ **Avoidance**:
avoiding people, situations or circumstances resembling or associated with the event

√ **Hyperarousal**:
hypervigilance for threat, exaggerated startle response, sleep problems, irritability and difficulty concentrating

√ **Emotional numbing:**

lack of ability to experience feelings, feeling detached from other people/ the world/ or the surrounding (Depersonalisation).

√ **Others**:
Depression, drug or alcohol misuse, anger, unexplained physical symptoms

◘ Management

♠ Watchful waiting may be used for mild symptoms lasting less than 4 weeks

♠ **First Line** → Trauma-focused cognitive **behavioural** therapy (TF-CBT).

If TF-CBT fails, → Eye movement desensitization and reprocessing (EMDR).

♠ **Second line** (**if CBT is not in the options**) → SSRI (Paroxetine, Fluoxetine, Sertraline).

In a recent exam, a man keeps on remembering a recent train accident that he witnessed and people dying. He keeps seeing flashbacks and nightmares of the accident. Since then, he struggles to sleep or concentrate, and avoid social events. He tried trauma-focused cognitive behavioural therapy but no response.

• The diagnosis was → post-traumatic stress disorder (PTSD).

• The question asked about the most appropriate management. The options included:

- Dialectical behavioural therapy (DBT),

- Cognitive analytic therapy (CAT), or

- Eye movement desensitization and reprocessing (EMDR).

The right answer was Eye movement desensitization and reprocessing (EMDR).

Careful: cognitive **analytic** therapy s different from cognitive **behavioural** therapy!

Example,

A 33 YO ♀ presents complaining of constant irritability when dealing with her small children, inability to concentrate, being easily startled, poor sleep, nightmares of house fire. Her husband died in a house fire last year.

♦ The likely Dx → **Post-traumatic stress disorder**.

♦ First line Rx → **Cognitive behavioural therapy (CBT)**. (**Trauma-Focused CBT**)

♦ If not in the options, pick **SSRIs**, eg, → **Fluoxetine, Sertraline, Paroxetine**.

Example 2,

A refugee always remembers the war that occurred in his country. He sees his family members who were killed in that war. He has poor sleeps and feels hopeless. He sometimes feels detached from his surroundings as if he is watching the world on the roof of his room.

♦ The likely Dx → **Post-traumatic stress disorder**.

Hints in this stem:
√ Flashbacks
√ Feeling detached from other people/ the world/ or the surroundings (Depersonalisation).

Example 3,

A 28 YO male who served in the army 6 months ago presents with lack of interest in enjoyable activities, feeling low and nightmares of gunfire. He avoids watching the news as it reminds him of war.

♦ The likely Dx → **Post-traumatic stress disorder (PTSD)**.

Nightmares / Avoidance

♦ The initial step → **Trauma-Focused Cognitive behavioural therapy (CBT)**.

Followed by → **Eye movement desensitization and reprocessing (EMDR)**.

2nd line → **SSRI**.

Key 22

Ganser Syndrome

√ **A person deliberately and consciously acts as if he or she has a physical or mental illness** when he or she is not really sick.
√ People with Ganser syndrome mimic behaviour that is typical of a **mental illness**, such as schizophrenia.
√ Ganser syndrome is sometimes called "**Prison Psychosis**" because it was first observed in prisoners.
(remember: **Ganser = Gangster "prisoners"** who claims **mental illness** to get a parole – release -).

Examples,

A prisoner was taken to hospital. He complains of hallucination. When he is asked questions, he provides wrong answers but in the correct category. E.g. when asked who is the prime minister of England, he answers "Bill Clinton".

Key 23

Agoraphobia = Fear of open spaces

Agoraphobia is the fear of going out into the open.
Patients feel anxiety when in crowds or public places.
They may avoid going out as they feel more comfortable at home.

Examples of Agoraphobia (features):

√ Scared (anxious) of travelling on a public transport (Buses, trains).
√ Scared of visiting a shopping mall.
√ Scared of leaving home.

Associated features:

Intense anxiety, **palpitations**, **sweating**, **hyperventilation**, **nausea**

Management

→ **Cognitive behavioural therapy with graded exposure therapy**.

Example 1,

A 23 YO male gets severe anxiety when he boards a train or goes to a shopping centre or leaving home. He would develop palpitations, nausea, feeling a strong desire to escape as soon as he enters a train or a mall. This has been happening for the past 3 years with a progressive pattern.

The likely Dx → **Agoraphobia**.

The most appropriate Rx → **CBT + Graded exposure**.

	Example 2, A 25 YO female complains of a 2-year feeling of severe anxiety when she goes out of the house. She develops palpitations, sweating, breathlessness and a sensation that she is about to die every time she leaves her house. This has started 2 years ago when she was attacked in the street. This condition prevents her from visiting friends and relatives. The likely Dx → **Agoraphobia**.
Key 24	◙ Opioid (e.g. Heroin) overdose → ***Low RR***, ***Low HR, Low BP***, ***Pinpoint pupils*** → give **Naloxone**. ◙ Opioid (eg, Heroin) addict wants to quit opiate, the drug that helps him combat withdrawal symptoms → **Methadone** ***Methadone*** *is the* ***Method*** *number 1 for (****detoxification****); reducing withdrawal symptoms in opioid addicts.*
Key 25	**Risk factors of Suicide** ♣ **Previous suicide attempts** and **previous self-harm** (**the biggest risk factors**). ♣ **Alcohol** and drug abuse. ♣ **Depression** and other mental illnesses. ♣ Low socio-economic status. **Q1)** If a stem gives you a scenario of a person who has all these risk factors, remember that the **previous suicide attempt** has the **greatest risk** to another suicide attempt.

	Q2) If a stem gives you a scenario of a person who has all these risk factors, **BUT without the First one (previous harm of self or suicide attempts**. Pick → **Alcohol misuse** as the greatest risk of suicide. **Q3)** A man with a previous suicide attempt presents to a GP with a new suicide attempt but he says that he regrets his suicide attempts → still **urgent referral to psychiatry**.
Key 26	Agitation + Euphoria + Necrotic/ Perforated nasal septum → **Cocaine misuse**. (Nasal inhalation is the routine route of Cocaine intake).
Key 27	**A 10 YO boy with behavioural problems is brought to a clinic by his parents. The boy shouts expletives, unable to sit still and constantly blinking.** → **Tourette's Syndrome**. --- ◙ **Tourette's syndrome** → **Repetitive multiple Tics** (motor + vocal), 6-13 YO child. • **Examples**: √ **Unable to sit still**, **constantly blinking**, making grunting noises, rubbing fingers. √ A child yelling in class intermittently, **shouting expletives**. √ **ADHD** "Attention Deficit Hyperactivity Disorder) frequently co-occurs in children with Tourette Syndrome → inattentiveness at class.

Remember, **Tics → Tourette**

◙ **Asperger Syndrome** → Affects **S**ocial interactions + behavioural problem.

◙ **Cotard's syndrome** → delusion of being already dead! (I'm dead)!, having now limbs, having no bowels and need to be buried.

◙ **Rett's syndrome** → Normal development until 2-3 YO. After that, a **Re**gression in motor, social, language, coordination skills occurs.

◙ **Ekbom's Syndrome** → Delusion of Parasite infestation. (I am infested by parasites).

♠ ***Do you remember restless-leg syndrome = (Willis-Ekbom Syndrome) from the CNS chapter?***

♠ ***A person feels as if there are insects crawling over his lower limbs, and when moving his legs, he gets a relief.***

√ Try to link "insects", "parasites" in both **Ekbom** and **Willis-Ekbom**; however, they are different.

√ Remember, in Restless-leg syndrome (Willis-Ekbom Syndrome):

→ **Check iron (ferritin)**

♦ **If low** → Give iron supplements (even if Hb is normal, what matters is ferritin)

♦ **If ferritin is normal** → Give **Dopamine agonist**

Key 28

◙ **Incongruent affect**

→ an "**Out of Place**" or "**conflicting**" **reaction**.

√ (Example → **a person talks about his father's death while laughing**)

√ Seen in **Schizophrenia** and **Bipolar**.

√ The patient is not aware that he is doing a wrong thing.

◙ **Flat Affect**

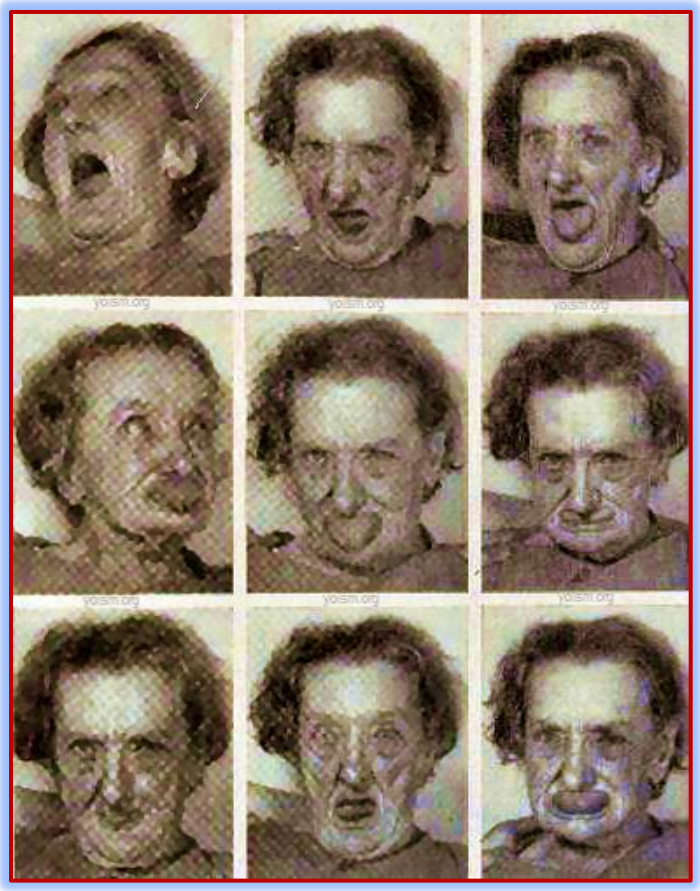
→ Monotonic voice with No Facial Expressions.

Key 29

HypOkalemia	HypeRkalemia
• **Loop Diuretics** (e.g. Furosemide) • **Thiazide-like diuretics** (e.g. bendroflumethiazide, indapamide) • **Vomiting** and **Diarrhea** • **Villous Adenoma** • **Renal tubular failure** • **Cushing Syndrome** • **Conn's disease** (1ry hyperaldosteronism)	• **ACE inhibitors**. • **Potassium-sparing diuretics** (e.g. Spironolactone/ Eplerenone) • **CKD**. • **Addison's** (1ry Adrenal Insufficiency). • **Congenital Adrenal Hyperplasia**.

Remember,

	Diuretics and **NSAIDs** can lead to **↑ serum lithium levels**. **A bipolar patient on lithium was found to have high serum lithium levels and hypokalemia. He has recently started an antihypertensive medication. What is this medication?** √ The **diuretic** that is used as **antihypertensive** and can cause **hypokalemia** is → **Thiazide like Diuretic (Bendroflumethiazide)**. √ Diuretics can also ↑ lithium levels.
Key 30	**Long-term use of antipsychotics** **+** **Continuous involuntary movements of tongue and lower face** ± extremities e.g. ***lip smacking***, ***tongue thrusting***, ***repetitive chewing movements*** ***± slow uncontrollable writhing movements of fingers/extremities.*** → **Tardive Dyskinesia**. → **Give depot injection of Atypical antipsychotic (e.g. Risperidone / Olanzapine)** Not oral!



Long-term use of antipsychotics (e.g. risperidone) +

Continuous sensation of restlessness and inability to sit still, sensation of uncomfortable desire to move, inability to relax and feeling anxious.

e.g. ***Fidgets***, ***pacing around the room to feel relieved***, ***repeats movements such as crossing and uncrossing legs.***

→ **Akathisia**.

Akathisia: a state of agitation, distress, and restlessness that is an occasional side-effect of antipsychotic and antidepressant drugs.

	Remember, **Huntington's disease** is characterised by **Chorea** "involuntary writhing -jerky- movement of a limb" ± FHx (autosomal dominant). **Cognitive impairment + Jerky involuntary movements + FHx → Huntington's**.
	Parkinsonism can also occur 2ry to antipsychotics but it occurs usually **1 week** after starting the antipsychotics (not after a prolonged use as in Tardive dyskinesia). It is also characterised by → **Resting tremors**, **Bradykinesia** and **Rigidity**.
Key 31	♦ **Broca's aphasia** → **B**roken speech. The problem is in speech production, otherwise normal. (non-fluent, slow speech, bad grammar, but they know and understand what they are saying "Good Comprehension"). ♦ **Wernicke's aphasia** → **W**hat? The problem is with speech comprehension = understanding. (Although fluent speech, they produce sentences that do not make sense, they do not know what they are saying). ♦ **Clang Association** → **Production of rhyming, music like sentences that has no correlation to one another and meaningless.** **Example**,

	"**I like to eat, we open a sheet, but do not play in street, because life is unfair, I eat air, lawn chair**" Clang → Slang speech (not literally though) ♦ **Pressure of Speech** → **Rapid and accelerated speech without any pause and ignores interruptions, barely even pauses to take enough breaths.** **Can be seen in mania (and bipolar).** ♦ **Flight of ideas** → **Thoughts and words leap from topic to topic = rapid speech with frequent shifts in topics abruptly.** **Can be seen in mania (and bipolar).**
Key 32	Remember that in a patient with **depression**, once there is **suicidal** thoughts/ attempts or **harm** to self or others, it is → **Severe Depression**. And the patient needs to be → **Compulsorily admitted to a psychiatric ward**. ***Note, do not jump into Electroconvulsive therapy. It is usually the last step.*** ◙ **Imp:** What if severe depression + Psychotic depression (with added hallucination e.g., hearing voices) → **Electroconvulsive therapy (ECT)**. After the course of ECT, the patient should be referred to cognitive behavioural therapy (CBT).

	Note: If a patient with suicidal thoughts, history of self-harm, and is aware of his condition and presents to the GP or ER and asks for help → **Crisis Team** is very useful for urgent mental health conditions such as psychotic patients or patients at high risk of suicide. They would triage, contact and visit the patient in 24 hours. The team has psychiatrists, psychologists, social workers and nurses. Another valid answer → Refer to or admit to **psychiatry**. If he is already in a psychiatry clinic (or ward) → **Electroconvulsive therapy** may be the valid answer. **Important:** **What if the patient has improved and no longer holds suicidal thoughts or harm to self or others and he requests to be discharged and to stop ECT?** In this case, we respect the patient's wishes as long as he has mental capacity, with no thoughts of harming himself or others, and with no psychotic symptoms. However, we offer other treatment modalities and follow ups.
Key 33	**After a Major life event** **(e.g., a death of a loved one, mass shooting, house fire…etc.):** ◙ **Normal grief reaction** (**< 6 months** after a major life event) **Stages →** **Denial & Isolation** → **Anger** → **Depression** → **Bargaining** → **Acceptance** Note, not all people pass through all 5 stages.

◙ **Adjustment Disorder** (< 6 months after a major life event)

A person is unable to adjust to or cope with a stress or a major life event. So, instead that the grief symptoms get decreased, they increase with time. Error in adjustment!

Another definition → A greater distress than expected to an event. (abnormal).

Crying / Hopeless / Withdrawn

Note that, normal grief is a subtype of adjustment disorder. Thus, you would be given either one, pick it as long as the duration is < 6 month of the major event.

√ ***Key → As long as it is < 6 months***

→ think adjustment disorder or its subtype which is Normal Grief reaction.

√ ***If > 6 months, think → Abnormal grief reaction.***

√ ***We cannot call it Depression yet. And also, it is not a PTSD because this would have flashbacks, nightmares, avoidance of things that remind the patient of the stressful event.***

Acute Stress Reaction

- Similar to PTSD (see below), but with a duration < 4 weeks
- It can start a **few min or hrs after** a stressful event, **last for < 4 weeks**.

Post-Traumatic Stress Disorder (PTSD) (**No specific time** after a major life event)

Flashbacks / **Nightmares** / **avoiding people, situations or circumstances resembling or associated with the event** / **exaggerated startle response** / sleep problems / irritability and difficulty concentrating / **feeling detached from surroundings**

In acute stress reaction and PTSD

→ Re-experiencing by flashback, night mares ▌Avoidance ▌hyperarousal.

These differentiate them from adjustment disorders and abnormal grief.

Key 34

Now, test your knowledge on this simple question:

A 32 YO man known case of severe depression on Sertraline (SSRI) for 2 years. He has recently committed a suicidal attempt but was rescued. 6 months ago, he suffered from mania and was admitted to the hospital. What is the best medication in his overall case?

He has **Depression**, and then developed **Mania**

→ **Bipolar Affective Disorder**.

So, he would benefit from

→ **Lithium "mood stabilisers"**

Very Important:
If a patient presents to a **primary care (ie, a GP)** with mood swings: good moods alternating with depression over periods [ie, **bipolar affective disorder**]"
→ **Refer to psychiatry** (secondary care).
(**Mood stabilizers** eg, **lithium** should be prescribed by **psychiatric** team).

(***Review key 8***).

Key 35

Antisocial Personality Disorder	• More common in men • Criminal acts – does not follow the rules • Impulsiveness • Aggressiveness, as indicated by repeated physical fights or assaults • Reckless • Consistent irresponsibility • Lack of remorse
Borderline Personality Disorder	• Unstable interpersonal relationships • Mood swings • Marked impulsivity • Self-harm attempts • Chronic feelings of emptiness • Inappropriate, uncontrollable anger • Dramatic, attention seekers e.g. "multiple self-inflicted scars"

◙ Male, past criminal records, aggressive, unstable relationships
→ **Antisocial**.

◙ Female, unstable relationship, impulsive, harming self, suicidal attempt
→ **Borderline**.

Example 1,

A 40 YO man was prisoned for breaking windows of a shop and hitting the salesperson on the head. He has criminal records with many previous convictions and had been imprisoned several times. He has 2 children and an ex-wife but he never contacts them.

The likely Dx → **Antisocial personality disorder**.

Example 2,

A 20 YO ♀ is brought to the ED by her boyfriend. She has multiple self-inflicted lacerations on her forearm. She is anxious, destressed and constantly says that her boyfriend will leave her.

The likely Dx → **Borderline personality disorder**.

Example 3,

A 40 YO ♂ had an appendectomy 1 week ago but returned to the hospital and started yelling and shouting as he was in pain due to the operation. He shouted on the Surgeon's face "you did not do the operation correctly and you did not tell me that it can cause discomfort". Then, he spited on the surgeon' face and said bad words and left. Two weeks later, he met the doctor on the street and approached him to apologise, thank him and to say that he is better now.

The likely Dx → **Borderline personality disorder**. √

Very impulsive, **inability to control anger**, **mood swings**

Sometimes, the given options would include would be just "personality disorder" without the word "borderline".

Example 4,

A 19 YO male was sent to jail as he has recently set his father's car on fire. He does not feel remorse or guilt. He finds it difficult to stick to the social rules and has no regards for the others' rights.

The likely Dx → **Antisocial personality disorder**.

Key 36

Selective serotonin reuptake inhibitors (SSRIs).

◙ Selective serotonin reuptake inhibitors (SSRIs) are considered first-line treatment for the majority of patients with **depression**.
◙ **Citalopram** and **fluoxetine** are currently the preferred SSRIs.
◙ **Sertraline** is useful post myocardial infarction as there is more evidence for its safe use in this situation than other antidepressants.
◙ SSRIs should be used with caution in children and adolescents. **Fluoxetine** is the drug of choice when an antidepressant is indicated.

√ **Gastrointestinal symptoms** are the **most common side-effect**.
√ There is an increased risk of gastrointestinal bleeding in patients taking SSRIs. √ A proton pump inhibitor should be prescribed if a patient is also taking a NSAID.

◙ Avoid concomitant use of SSRI with: NSAIDs/ Aspirin/ Warfarin/ Triptans.

◙ **IMPORTANT**:

SSRIs can take 2-4 weeks before antidepressant effect can be seen

√ **if no response after 2-4 weeks** → **Check patient's adherence (compliance).**
√ **if no response after 4 weeks + the patient is compliant**
→ **either ↑ dose or switch to another antidepressant "other than SSRIs"**.

Example 1,

A 33 YO man has depression and has been recently started on sertraline (a SSRI). When can a therapeutic effect be seen?
1-2 hours ▌1-2 day ▌**1-2 weeks** ▌1-2 months

The closer answer to 2-4 weeks.

Example 2,

A woman with moderate depression has been on Fluoxetine (SSRI) for 8 weeks but with no benefit or improvement. Her adherence is good. What should be done next?
Give lithium ▌**shift to Mirtazapine** ▌give sodium valproate ▌Diazepam
ECT (Electroconvulsive therapy)

√ **Lithium** is for bipolar.
√ **Sodium valproate** is an anti-epileptic.
√ **ECT** is usually not prescribed until very severe depression and all other medications have failed (as a last line).
√ **Diazepam** is not licensed for depression treatment.

So, the answer here
→ **Stop fluoxetine and prescribe Mirtazapine**

(If **increasing the dose of fluoxetine** was given, it might have been a valid answer)

Shifting to a different class of antidepressant. The alternative class given her is presynaptic alpha 2 antagonist (e.g. mirtazapine) which is an Atypical antidepressant.

Remember the steps of Depression Management

♦ Start with SSRIs (e.g. Fluoxetine, Sertraline).

♦ No response in 2-4 weeks? → Check patient's adherence to the medication.

♦ Patient is adherent but still no response after 4 weeks of use?

→ either ↑ the dose of SSRI OR Shift to a different SSRI

OR shift to a different class of antidepressants (eg, Mirtazapine – which is a tetracyclic antidepressant – a presynaptic alpha 2 antagonist-)

◙ Some Side effects:

√ Haloperidol → Sexual Dysfunction + Gynecomastia.

√ Fluoxetine (SSRI) → Anorgasmia (delayed ejaculation).

Other: SIADH "hyponatremia"

*So, in a man who **has erection** but **no or delayed ejaculation***

The causative drug is → ***Fluoxetine***

	For Reading: **√** Following the initiation of antidepressant therapy patients should normally be reviewed by a doctor after 2 weeks. For patients under the age of 30 years or at increased risk of suicide they should be reviewed after 1 week. If a patient makes a good response to antidepressant therapy, they should continue on treatment for at least 6 months after remission as this reduces the risk of relapse. **√** When stopping a SSRI, the dose should be gradually reduced over a 4-week period (this is not necessary with fluoxetine). Paroxetine has a higher incidence of discontinuation symptoms. **√ Discontinuation symptoms:** increased mood change, restlessness, difficulty sleeping, unsteadiness, sweating, gastrointestinal symptoms: pain, cramping, diarrhoea, vomiting, paraesthesia
Key 37	**Again**, remember that once a psychotic patient is at **risk for self-harm or others-harm** → **urgent admission to psychiatric ward is required**. This can be **voluntary** (if he accepts) or **compulsory** (if he refuses admission). ***Example***, A 40 YO man has recently been hearing voices in the house while no one is in the house. He says that his neighbours are annoying him by turning on loud music during the middle of the night. He warned them but they denied this act. Out of rage and frustration, he had made plans to set their house on fire. → **Arrange emergency admission to Psychiatric ward**.

Key 38

Rapid Tranquilisation. E.g. in Acute Psychosis

Lorazepam → Haloperidol → Olanzapine (can be given IM)

◙ In acute episode of psychosis, the drug of choice is

→ **Haloperidol** (especially in the elderly)

◙ NOTE, Haloperidol is **contraindicated** if there is ***parkinsonism*** or ***Alzheimer's***.

If the patient has Parkinson's or Alzheimer's, give → Lorazepam instead.

Example,

An 80 YO schizophrenic man is brought to the ED agitated. He is aggressive, attacking the staff. He has no IV access.

The Rx → **Haloperidol**. "**it can be given IM**".

If a patient with **delirium/ psychosis** has become **aggressive/ agitated/ distressed** and he has **NO** Dementia, Alzheimer's, or Parkinson's → we could consider **Haloperidol** or **Olanzapine** **as a short-term therapy if non-pharmacological (de-escalation) techniques have failed.**

In general, acutely to calm him down, give lorazepam.

√ If the patient has Parkinson's or Alzheimer's, give → Lorazepam instead.

√ If Haloperidol is not in the options, pick → Lorazepam "can be given IM"

	Example, A 30 YO woman was brought to the ED by the ambulance in an agitated state. She was roaming around the streets, shouting, laughing hysterically, throwing money and saying "I am going to die". She was admitted compulsorily. However, she continues to be agitated and tried to escape from the hospital. What medication should be given? → **IM Lorazepam** If it does not work → **IM Haloperidol**. **Remember: rapid tranquilisers (eg, in acute episodes of psychosis) are: Lorazepam, Haloperidol, Olanzapine.** ***Example,*** A 37 YO man was seen by his wife shouting at the neighbours in the morning. He seems angry and agitated. She brought him to the A&E and while waiting the doctors, he was shouting and yelling and accusing the doctors that they want to steal his wallet. What should be given to calm his aggression? → **Lorazepam** "not diazepam".
Key 39	When someone has a problem but he **does not recognise** that he has a problem → **He Lack insight**

	When someone has a problem and he **recognise** that he has a problem → **He has insight** Example, A 24 YO ♀ had misused a drug and presented to the ED on her own as she knows that she has a problem and is willing to see a psychiatrist. √ The best term to describe this situation is → **Insight**.
Key 40	**With Social anxiety**: ♦ If the stem is describing someone who wants to deal with an **upcoming event** (**short term**) → **Propranolol**. ♦ If he wants to **prevent further attacks** → **SSRIs**. ♦ If he is having the attack and presents **acutely** → **breathe into a bag**. **Example**, A 24 YO man feels anxious and agitated when faced with stress. He has an interview in 3 days and wants some help to reduce his symptoms for the interview. → **Propranolol** (beta blockers). "Short-term" (***Imagine he received diazepam before heading to the interview, he would sleep during the interview :S***).
Key 41	**Erotomania** → a delusional belief that a person of higher social status falls in love and makes amorous advances towards him/her.

	Example, A 32 YO woman believes that a famous politician is in love with her and secretly sending her flowers every day. She says that some of his public speech is hints that he loves her. **Eroto** = **Erotic** = **Love** **Erotomania, when love is a delusion!** **Pyromania** → an impulse control disorder in which individuals repeatedly fail to resist impulses to deliberately start fires in order to relieve tension or for instant gratification. (**Strong desire to set fires**)! Pyr = Fire **Trichotillomania** (TTM) → also known as "hair pulling disorder", is a mental disorder characterized by a long-term urge that results in the pulling out of one's hair. (**Strong desire to pull people's hair**) :S **Rejected Stalkers** → follow their victims in order to reverse, correct, or avenge a rejection (e.g. divorce, separation, termination).
Key 42	**Folie à deux**, **shared psychosis**, or shared delusional disorder is a psychiatric syndrome in which symptoms of a **delusional belief and sometimes hallucinations are transmitted from one individual to another**. ***Example,*** A woman believes that her neighbours use her bathroom and dry it and leave when she is outside the house. Her husband shares the same belief as well.

Key 43

Serotonin syndrome

After overdose of **SSRI** (e.g. **Fluoxetine**)

Features

√ Neuromuscular excitation (e.g. hyperreflexia, myoclonus, rigidity)
√ Autonomic nervous system excitation (e.g. hyperthermia)
√ Altered mental state
√ Nausea, diarrhea.

Similar features can be seen after (**Dopamine antagonist**) e.g. **Metoclopramide** overdose or Potent antipsychotic e.g. **Clozapine**, **risperidone** but the syndrome is called → **Neuroleptic malignant syndrome**

In short,

◘ Excess intake of **SSRIs** (e.g. Fluoxetine, Sertraline, Citalopram)

→ fever, sweating, tachycardia, agitation, confusion, muscle rigidity/ twitching, neck stiffness, others

→ **Serotonin Syndrome**.

◘ Excess intake of **Dopamine antagonist** (e.g. **Metoclopramide/ Haloperidol), or potent antipsychotics (e.g. Clozapine, risperidone).**

→ fever, sweating, tachycardia, agitation, confusion, muscle rigidity/ twitching, neck stiffness, others.

→ **Neuroleptic Malignant Syndrome**.

Key 44

LSD Overdose	Mydriasis (Dilated pupils) – Flushing and sweating – Tremors – Hyperreflexia-Diarrhea – Paraesthesia **Delusions and Hallucinations** (Pathognomonic) - a patient smelling colours and seeing sounds → **LSD** **Patients see colours when their eyes are closed.** **More pronounced hallucination compared to ecstasy. E.g., the colours are changing.**
Ecstasy Overdose	Nausea, flushing, Hyperthermia, Tachycardia, Tachypnea, Thirst **Seeing spots of colour around peripheral vision (when eyes are open).**

Key 45

Remember,

√ **Panic disorder** is episodic. (several attacks that last 20-30 minutes).

√ **GAD** (Generalised Anxiety Disorder) is almost all time for a long period.

Key 46

Paracetamol overdose (Poisoning): .

Management

All patients are treated the same regardless of risk factors for hepatotoxicity.

• On Admission → FBC, U&E, LFT, INR, Blood gases, Glucose,

• Serum paracetamol level at **4 hours** **Post-ingestion** (NOT POST-ADMISSION).

IV N-Acetylcysteine should be given if:

• There is a **staggered** overdose (all the tablets were not taken within 1 hour)

• There is **doubt over the time** of paracetamol ingestion, regardless of the plasma paracetamol concentration.

• Patients **present > 8 hours** after ingestion.

• **Jaundice** or **liver tenderness**.

• The Patient is **unconscious** or have a suspected overdose.

• The **4-hour post ingestion plasma paracetamol concentration is on or above treatment line** regardless of risk factors of hepatotoxicity

◙ **N.B. If a patient presents after ingesting 30 tablets of paracetamol but without any other indications for initiating N-Acetylcysteine. What to do?**

→ **Measure the paracetamol levels at 4 hours post-ingestion (Calculated from the time of ingestion, not from the time of hospital arrival) before commencing N-Acetylcysteine.**

◙ **N.B.** If the Serum paracetamol level is found to be normal?

→ **Refer to psychiatric team.**

(This is because No Medical treatment is required, the referral to psychiatry aims at preventing recurrent attempts of suicide and treating any psychological abnormalities).

Notes:

- The **critical dose is** 150mg/kg in 24 hours (approximately for adults **24 tablets** = 12 grams).

- **Oral activated charcoal** is given 1g/kg (Max: 50 g) if the patient presents within **1 hour** after ingesting ≥ 150mg/kg paracetamol.

- Paracetamol poisoning is dealt with in the **medical ward** not in the psychiatric. However, after a discharge from medical ward, a referral **to psychiatric team** is usually made.

When to refer a patient with paracetamol overdose for Liver Transplantation? (Imp)

King's College Hospital criteria for liver transplantation (Paracetamol Liver Failure):

◙ **Arterial pH < 7.3, 24 hours after ingestion**

◙ **Or all** of the following:
- Prothrombin time (PT) > 100 seconds
- Creatinine > 300 µmol/l
- Grade III or IV encephalopathy

A quick example, "***More examples are in the Emergency Chapter***"

	After her boyfriend ends their relationship, an 18 YO female has taken 10 tablets of paracetamol after drinking alcohol. What should be done? √ 10 tablets are usually not poisonous. (remember the critical dose is 24 tablets). √ Acute alcohol intake → inhibits P450 enzyme → ↓ risk of paracetamol poisoning. She does not need a medical ward admission; however, she needs mental stabilisation. Therefore → **Refer to psychiatry**.
Key 47	◙ Hallucinations that begin **a few hours** after acute alcohol intake has been stopped → **Alcohol Hallucinosis**. "*Usually accusatory and threatening sounds*" ◙ Hallucinations that begin > 48 hours after alcohol intake in a "chronic alcoholic" → **Delirium Tremens**
Key 48	A 45 YO man with low moods, anhedonia "inability to feel pleasure.", poor sleeping and eating. He feels guilty because he was not faithful to his wife who has a terminal stage breast cancer. In fact, his wife is healthy and does not have a Dx of breast cancer. The likely Dx → **Psychotic depression** √ He has features of **depression** → low mood, anhedonia, poor eating and sleeping. + √ Features of **psychosis** → Delusions of guilt, Delusions that his wife has cancer.
Key 49	**Alcohol Use Disorders Identification Test (AUDIT) questionnaire**

	√ Can detect whether you are an alcohol addict or not. **Important signs that indicate that a person is an alcohol addict:** **♦ Drinks immediately after waking up.** **♦ Feels guilt or remorse after drinking.** **♦ A man drinks ≥ 8 units on a single occasion/ A woman drinks ≥ 6 units on a single occasion.** **♦ Unable to remember what happened last night because of being drunk.** **♦ Self or other injury because of being drunk.** **♦ Once starts drinking, he/ she cannot stop.** **♦ A health professional is concerned about his/ her drinking.**
Key 50	**Important Collection of Management (Psychology)** ◙ **Depression** → **√** First line is cognitive behavioural therapy (by a psychologist, not psychiatrist). If CBT, refer patient to counselling. **√** If severe and medications needed → SSRIs (e.g., Fluoxetine, Sertraline, Paroxetine). (**Note**: The best SSRI in patients with MI → Sertraline, followed by Citalopram). (**Note**: The best SSRI in breastfeeding women → Sertraline). **√** If SSRIs failed in 2-4 weeks → Check the patient's adherence to medications. If he is adherent but still no response after 4 weeks of use → ↑ dose or shift to a different class, e.g., Mirtazapine/ Clozapine. ◙ **Acute Psychosis** "An agitated, aggressive psychotic" √ Elderly without Parkinson's or Alzheimer's → Haloperidol.

√ Young or anyone with Parkinson's or Alzheimer's → Lorazepam (rapid tranquilizer).

◙ **Tardive Dyskinesia** and **Schizophrenia**
→ Depot Atypical antipsychotics (eg, Risperidone / Olanzapine)

◙ **Obsessive compulsive disorder (OCD)** and
Post-traumatic stress disorder (PTSD) and
Generalised anxiety disorder and **Social anxiety disorder**:
√ First Line → cognitive behavioural therapy (CBT).
"Sometimes → Exposure and Response Prevention (ERP) is the right answer as it is a part of CBT"
√ Second line → SSRIs
Note: in post-traumatic stress disorder, if trauma-focused **CBT** fails, we try eye movement desensitization and reprocessing (**EMDR**).

◙ **Borderline personality disorder**
√ The cornerstone → **Cognitive behavioural therapy (CBT)**.
√ Another valid answer → **Dialectical behavioural therapy** (**DBT**): It is an important treatment choice in **borderline personality disorder**. It is a type of talking therapy based on cognitive behavioural therapy (CBT). It is more suitable for people who feel emotions more intensely as it concentrates on the emotional aspects.

◙ **Panic Disorder** Management simplified:
√ Rx before attack (to help in an upcoming event) → Propranolol (Beta-blocker).
√ Rx during attack → Rebreathe into a paper bag.

	√ Long-term Rx and to prevent further attacks → 1st: Psychological → CBT. → 2nd: Medical → SSRIs. ◙ **Bipolar affective disorder** → **Lithium** (**Mood stabiliser**). **Very Important**: If a patient presents to a **primary care (ie, a GP)** with mood swings: good moods alternating with depression over periods [ie, **bipolar affective disorder**]" → **Refer to psychiatry** (secondary care). (**Mood stabilizers** eg, **lithium** should be prescribed by **psychiatric** team). ◙ **Baby-blues** → Reassurance. ◙ **Postnatal Depression** → CBT, then (SSRIs) "Sertraline is the best SSRI in a breastfeeding mother" ◙ **Puerperal "Postpartum" Psychosis** → Electroconvulsive Therapy (ECT).
Key 51	**A woman believes that her neighbours use her bathroom and dry it and leave when she is outside the house. Her husband shares the same belief as well** → **Folie à deux** = **shared psychosis (A form of: Psychosis)**

Key 52	**A 40 YO man has recently been hearing voices in the house while no one is in the house. He says that his neighbours are annoying him by turning on loud music during the middle of the night. He warned them but they denied this act. Out of rage and frustration, he had made plans to set their house on fire.** → **Arrange emergency admission to Psychiatric ward**. Remember that once a psychotic patient is at **risk for self-harm or others-harm** → **urgent admission to psychiatric ward is required**. This can be **voluntary** (if he accepts) or **compulsory** (if he refuses admission).
Key 53	**A 40 YO man has recently been hearing voices in the house while no one is in the house. He says that his neighbours are annoying him by turning on loud music during the middle of the night. He warned them but they denied this act. Out of rage and frustration, he had made plans to set their house on fire.** → **Arrange emergency admission to Psychiatric ward**. Remember that once a psychotic patient is at **risk for self-harm or others-harm** → **urgent admission to psychiatric ward is required**. This can be **voluntary** (if he accepts) or **compulsory** (if he refuses admission).

Key 54	**An agitated woman believes that she is important as she is helping very important people.** → **Delusion of grandiosity**.
Key 55	**A young lady with recurrent attacks of palpitations, tremors, anxiety and nervousness that develop rapidly and resolve in a few minutes.** → **Panic Attacks**.
Key 56	**A 40 YO ♂ had an appendectomy 1 week ago but returned to the hospital and started yelling and shouting as he was in pain due to the operation. He shouted on the Surgeon's face "you did not do the operation correctly and you did not tell me that it can cause severe discomfort". Then, he spited on the surgeon' face and said bad words and left. Two weeks later, he met the doctor on the street and approached him to apologise and to say that he is better now and to thank him.** The likely Dx → **Borderline personality disorder**. **Very impulsive**, **inability to control anger**, **mood swings.** **Dialectical behavioural therapy (DBT)** is an important treatment choice in **borderline personality disorder**. It is a type of talking therapy based on cognitive behavioural therapy (CBT). It is more suitable for people who feel emotions more intensely as **it concentrates on the emotional aspects**.

Key 57	**A man tends to wash his hands several time as he believes that the germs have not been removed and he needs to wash his hands again and again.** → **Obsessive compulsive disorder (COD).**
Key 58	**An 18 YO female with BMI of 13.5 has reduced her food intake for a few months, No menstruation for 1 year, BP 70/50, HR 46. She is dehydrated and hypoglycemic.** → **Admit to Medical ward**. (Anorexia Nervosa with serious medical complication). If she refuses to be admitted → **Assess for compulsory admission**.
Key 59	**An elderly with Parkinson's disease has developed an episode of acute psychosis and becomes aggressive. He punches everyone approaching him in the face.** The most appropriate immediate Rx → **Lorazepam** (for rapid tranquilization) • **Lorazepam** is a rapid acting benzodiazepine. (Could be given IM here). • **Haloperidol** (**T**ypical Anti-psychotic) is contraindicated in elderly with psychosis/ dementia especially in Parkinson's disease patients. • **Olanzapine** and **Risperidone** (**At**ypical Antipsychotics) can exacerbate Parkinson's disease.

	Note, if the aggressive/ distressed patient has **no** Dementia, Alzheimer's, or Parkinson's → we could consider **Haloperidol or Olanzapine as a short-term therapy if non-pharmacological (de-escalation) techniques have failed.**
Key 60	**A man hears voices commenting on his action such as (He is no getting out of bed. He is opening the door).** → **Third person hallucination**. (A feature in schizophrenia). --- **Third-person auditory hallucination** (**important √**) Example → A voice is heard saying (**he**/**she**). "**He is evil**", "He is moving", "**She is opening her phone**". "**He is getting up**. **Now, He is going towards the window**" **Second-person auditory hallucination** Example → A voice is heard saying (**You**). "You are evil", "You are moving", "You are opening your phone". **First-person auditory hallucination** Example → A voice is heard saying (**I am**). "I am lying down", "I am moving".

Key 61	**Risk factors of Suicide** ♣ Previous suicide attempts and previous self-harm (**the biggest risk factors**) ♣ Depression and other mental illnesses. ♣ Alcohol and drug abuse. ♣ Low socio-economic status. **A person with all these risk factors. What is the greatest risk?** → **previous suicide attempt = Previous self-harm**
Key 62	**A 65 YO man has just suffered from myocardial infarction and is now to be discharged. He feels sad, avoids eye contact, and skipped his last 2 meals.** The likely Dx → **Depression** √ Rx → **Sertraline** (**The best SSRIs in MI is Sertraline**). If not in the options, pick (**Citalopram**) "the 2nd line SSRI in MI patients"
Key 63	◙ A 45 YO man with low moods, anhedonia "inability to feel pleasure.", poor sleeping and eating. He feels guilty because he was not faithful to his wife who

has a terminal stage breast cancer. In fact, his wife is healthy and does not have a Dx of breast cancer.

The likely Dx → **Psychotic depression**

√ He has features of **depression** → low mood, anhedonia, poor eating and sleeping.

+

√ Features of **psychosis** → Delusions of guilt, Delusions that his wife has cancer.

Key 64

Important Differential Diagnoses

◙ An 18 YO female with BMI of 13.5 has reduced her food intake for a few months, No menstruation for 1 year, BP 70/50, HR 46. She is dehydrated and hypoglycemic.

The likely Dx → **Anorexia Nervosa**.

◙ 19 YO ♀, BMI 21, thinks that she is obese. She eats uncontrollably and then feels guilty and thus performs self-inducing vomiting and or heavy exercises.

The likely Dx → **Bulimia Nervosa**. "**Classic case**".

◙ 19 YO ♀, BMI 21, thinks that she is obese. She eats uncontrollably and then feels guilty BUT she **doesn't** perform self-inducing vomiting and or heavy exercises.

	The likely Dx → **Binge eating disorder**. In both bulimia nervosa and binge eating, the patient eats a lot and feels guilt and regret after that. However, **the main difference** between them is that binge eating disorder is **not** followed by purging or compensatory actions to lose weight such as excessive exercises, inducing vomiting, using laxatives. ◙ 18 YO ♀, BMI is 17.8, has bilateral parotid swelling, and thickened calluses on the dorsum of her hands. The likely Dx → **Bulimia Nervosa**. "**BMI > 17.5 + Parotid swelling**". ◙ A 30 YO ♀, 6 months history of **recurrent regurgitation of undigested** food into the mouth that occur minutes after eating. The regurgitation is not preceded by nausea but it is often accompanied by **repetitive burping**. She eats large amounts over a short period without any compensatory behaviours like vomiting or excessive exercise. The likely Dx → **Rumination Syndrome**.
Key 65	◙ A woman has delivered a baby 6 weeks ago. She feels sad and has no interest to feed her baby. She eats poorly and has poor sleeps. She says that the baby has evil eyes. √ The likely Dx → **Post-partum psychosis**. √ Clues: baby has **evil eyes** – lacks caring for baby.

Key 66	***√ Checks the doors several times.*** ***√ Turn the light on and off several times.*** → **Obsessive compulsive disorder (OCD)** Rx → Cognitive behavioural therapy (CBT)
Key 67	**A renal cancer patient who was on morphine with good pain control started vomiting, and was placed on metoclopramide. He developed neck stiffness and rigidity. What is responsible for the symptoms?** a. **side effect of metoclopramide** b. side effect of opioid c. meningitis d. cerebral metastasis ◘ Excess intake of **SSRIs** (e.g. Fluoxetine, Sertraline, Citalopram) → fever, sweating, tachycardia, agitation, confusion, muscle rigidity/ twitching, neck stiffness, others → **Serotonin Syndrome**.

	◘ Excess intake of **Dopamine antagonist** (e.g. **Metoclopramide/ Haloperidol), or potent antipsychotics (e.g. Clozapine, risperidone).** → fever, sweating, tachycardia, agitation, confusion, muscle rigidity/ twitching, neck stiffness, others. → **Neuroleptic Malignant Syndrome**. **Management?** √ Stop medication. √ Rapid cooling. √ Dopaminergic agents (e.g. bromocriptine).
Key 68	◙ A 65 YO man has just suffered from **myocardial infarction** and is now to be discharged. He feels sad, avoids eye contact, and skipped his last 2 meals. The likely Dx → **Depression** **√** Rx → **Sertraline** (**The best SSRIs in MI is Sertraline**). If not in the options, pick (**Citalopram**) "the 2nd line SSRI in MI patients"
Key 69	A man with **bipolar disorder** for 10 years and knee pain for which he takes **ibuprofen** develops **tremors**, **vomiting** and **confusion** while travelling a long distance.

	The most appropriate test to be done → **Serum Lithium concentration**. Note, **Diuretics** and **NSAIDs** (e.g. Ibuprofen) increases renal reabsorption of lithium and hence, the **serum lithium increases** and may lead to toxicity.
Key 70	◘ **A woman persists that she has pancreatic cancer just like her dead husband.** ◘ **A person believes that his benign lump is a cancer despite all reassuring investigations.** ◘ **A minor headache is caused by a brain tumour.** ◘ **Tiredness is caused by HIV.** ◘ **A mild rash is the start of skin cancer.** → **Hypochondriasis (Hypochondriacal disorder)** ◙ **A woman with depression after the death of her husband has completed 6 months of SSRI and thus, he stopped taking her medication. After a while, she develops a feeling that she has pancreatic cancer just like her dead husband.** The likely Dx → **Hypochondriacal delusion**. The next step → **Neuropsychiatric analysis**

Key 71	◙ The hormonal disturbance in Schizophrenia is → **dopamine**
Key 72	◙ After the death of his wife 6 months ago, a 55 YO man developed severe depression. He thinks there is no point in living anymore and refuses any help or treatment. He has multiple lacerations on his forearm. What should be done? → **[Compulsory] Admission under Mental Health Act**. √ As **he refuses** any medical support, "**voluntary**" admission is **not** suitable. √ This law allows to admit people with mental disorders **compulsorily** "**against their well**" as long as there is risk either on themselves or on others.
Key 73	**A 40-year-old woman who present to the clinic with 1-week history of multiple physical symptoms: headache, abdominal pain, weaknesses, urinary frequency and bloatedness. Physical examination and investigations were normal. What is the likely diagnosis for her condition?** D. Conversion disorder B Factitious disorder C Hypochondriasis D malingering E **Somatisation disorder**

	Somatisation disorder **√ Multiple physical SYMPTOMS** **"SoMatisation = So Many symptoms and investigations with no physical cause"** **√ Patient refuses to accept reassurance or negative test results.**
Key 74	**A 45 yr old woman who has had 4 episodes of palpitations, hyperventilation and tachycardia in the last 1 month associated with worry, feeling she would lose her life. What is the most likely diagnosis?** A) social phobia B) Generalized anxiety disorder C) **Panic disorder** D) Obsessive Compulsive disorder E) Cotard's In **GAD**, the symptoms are **long-lasting** while **panic attacks** are **short** (10-30 minutes). i.e., the symptoms in **GAD** are present nearly **all the time**, whereas the symptoms of **Panic disorder** are **Episodic**/ **Sudden** "even if they occur every day, as long as they are sudden episodes, it is Panic Disorder".

Key 75	**Man with 3-month Hx of low mood, insomnia, worthlessness. Hx of Benign prostatic hyperplasia, Hypertension and MI. what to give?** a. Amitriptyline b. Duloxetine c. **Sertraline** (**The best SSRIs in MI is Sertraline**). If not in the options, pick (**Citalopram**) "the 2nd line SSRI in MI patients" Remember that Sertraline is also of choice in breastfeeding ♀ √.
Key 76	**A patient in depression. Switched from fluoxetine to citalopram. Presents with painful right red eye with visual blurring.** A. fusidic acid eye drop B. Urgent referral to psychiatric C. **Urgent referral to ophthalmology** D. clomipramine **Citalopram (a SSRI) is associated with acute angle-closure glaucoma as one of the side-effects.**

Key 77	**An old patient accompanied by his son presents to A&E with low mood 6 months after his wife death. He is having suicidal thoughts and does not want to live anymore. His son is concerned about his father. He takes Warfarin for Atrial Fibrillation. What is the most appropriate management?** A. CBT B. Psychodynamic therapy C. Sertraline D. **Mirtazapine** E. Olanzapine • For patients on **Warfarin ± Heparin** presenting with **Depression**, do **not** give SSRI. Instead, we give **Mirtazapine**. • Note, taking Warfarin + Mirtazapine may rise INR slightly. • Mirtazapine is not a SSRI; it is presynaptic alpha 2 antagonist.
Key 78	**An 8-year-old boy was brought in by his parents because of some behavioural problems. In an interview with his teacher, he described the boy as naughty, easily distracted and sometimes aggressive. His parents say that he has always had difficulty concentrating on tasks since infancy. What is the most likely diagnosis?**

A. Autism spectrum

B. **ADHD**

C. Asperger's

D. Tourette

E. Oppositional defiant disorder

Attention Deficit Hyperactivity Disorder ADHD

Diagnostic Features

Attention Deficit (inattention)	Hyperactivity/Impulsivity
Does not follow through on instructions	Unable to play quietly
Reluctant to engage in mentally-intense tasks	Talks excessively
Easily distracted	**Does not wait their turn easily**
Finds it difficult to sustain tasks	Will spontaneously leave their seat when expected to sit
Finds it difficult to organise tasks or activities	Is often 'on the go'
Often forgetful in daily activities	**Often interruptive or intrusive to others**
Often loses things necessary for tasks or activities	Will answer prematurely, before a question has been finished
Often does not seem to listen when spoken to directly	Will run and climb in situations where it is not appropriate

	• **ADHD Symptoms**: Distractibility, forgetfulness, inability to complete tasks. • **First-line Treatment of ADHD:** → **Methylphenidate** (which is a stimulant medication that helps improve attention and focus and reduces hyperactive and impulsive behavior).
Key 79	**77-year-old man, whose son noticed that he has been depressed since his wife died 6 months ago. Has depressive symptoms with suicidal tendencies and doesn't think he can go on living. Q also said that the patient h'd severe self-neglect. What to do next?** A. Emergency Psychiatric referral B. **Urgent Psychiatry admission** C. urgent psychiatric review D. Routine Psychiatric referral Whenever there is a **risk of harm to self or others**, the patient needs to be **admitted**.
Key 80	**A 23-year-old man with a recent habit of handwashing. He washes his hands from left to right several times. He is always afraid of germs. There is a family HX of anxiety and depression. What is the most appropriate management?** A. Antidepressants B. **Cognitive behavioural therapy (CBT).**

	Therapy D. benzodiazepine E. beta blockers This is a likely case of **OCD** (Obsessive Compulsive Disorder) → **CBT** (Cognitive behavioural therapy).
Key 81	**A lady argued with her boyfriend and then she cut her wrist. She also drank so much alcohol. She has intense mood swings but does not want to die. The likely diagnosis?** A) **Borderline personality disorder**. B) Histrionic. C) Anti-social personality disorder. D) Avoidant. E) obsessional.

Antisocial Personality Disorder	• More common in men • Criminal acts – does not follow the rules • Impulsiveness • Aggressiveness, as indicated by repeated physical fights or assaults • Reckless • Consistent irresponsibility

	• Lack of remorse
Borderline Personality Disorder	• Unstable interpersonal relationships • Mood swings • Marked impulsivity • Self-harm attempts • Chronic feelings of emptiness • Inappropriate, uncontrollable anger • Dramatic, attention seekers e.g. "multiple self-inflicted scars"

◙ Male, past criminal records, aggressive, unstable relationships

→ **Antisocial** personality disorder.

◙ Female, unstable relationship, impulsive, harming self, suicidal attempt

→ **Borderline** personality disorder.

Key 82

A woman who became depressed after husband's death of cancer. She was using amitriptyline. Her appetite had improved. She used the antidepressant for 3 months and wanted to stop. What is the best advice?

A. Stop amitriptyline

B. **Encourage to continue amitriptyline**

C. Change to SSRI

	D. ECT E. Bereavement counselling √ Antidepressants are not addictive. √ For fear of relapse, it is advised that antidepressants are continued for **at least 6 months in total even if there is improvement** as in this case. √ So, the advice would be → **Continue amitriptyline for another 3 months**.
Key 83	**A 32-year-old man presents with erectile dysfunction of 2 months. He had depression 3 months ago and was started on Sertraline. He has no medical history of note. What is the most likely cause of his symptoms?** A. **Sertraline side effects** B. Autonomic neuropathy C. Performance anxiety D. Depression SSRI-induced **sexual dysfunction** can occur in both men and women. SSRIs examples → (Fluoxetine, Sertraline, Citalopram)
Key 84	**Points on Treatment of Depression:**

	◘ **SSRIs (e.g. fluoxetine, sertraline) are first line in moderate to severe depression.** ◘ **If there is Myocardial Infarction → Sertraline "1st line" or Citalopram "2nd line".** ◘ **If the patient is on warfarin → Mirtazapine (because SSRIs can cause GI bleeding if taken with Warfarin).** ◘ **Also remember that if SSRIs do not work with a patient, we can use another family such as Mirtazapine (which is an atypical antipsychotic: presynaptic alpha 2 adrenoreceptor antagonist).** ◘ **TCA (e.g. Amitriptyline) is the drug of choice in psychotic depression. It should be continued for 6-9 months after resolution of symptoms.** **(i.e. It cannot be discontinued if less than that even if there is improvement).**
Key 85	♣ Previous suicide attempts and previous self-harm are **the biggest risk factors for suicide**. ♣ Traumatic events during childhood are significant risk factor for depression. For example, traumatic effect caused by parental divorce.
Key 86	Remember that in a patient with **depression**, once there is **suicidal** thoughts/ attempts or **harm** to self or others, it is → **Severe Depression**

	And the patient needs to be → **Compulsorily admitted to a psychiatric ward**. *Compulsory admission = (Sectioning) is used when the patient is a danger to himself or to others.* ***Note, do not jump into Electroconvulsive therapy (ECT). It is usually the last step.*** **Important:** **What if the patient has improved and no longer holds suicidal thoughts or harm to self or others and requests to be discharged and to stop ECT?** In this case, we respect the patient's wishes as long as he has mental capacity, with no thoughts of harming himself or others, and with no psychotic symptoms. However, we offer other treatment modalities and follow ups.
Key 87	**Intoxication Important Examples:** • Antisocial behaviour, sweating, salivating, retching, vomiting, ataxia, disorientation, hypoglycemia, sometimes with dilated pupils that react slowly to light → Think **Alcohol** intoxication. "note that acute alcohol intoxication may cause auditory hallucination" • Altered consciousness, low RR, low HR, miosis (pinpoint pupils) ± appear unkempt ± needle track marks. → Think **Heroin** intoxication. • Agitation + Euphoria + Necrotic/ Perforated nasal septum. Others (high RR, high HR, high BP, Mydriasis). → Think **Cocaine misuse**. (nasal inhalation is the routine route of Cocaine intake).

Key 88

Long-term use of antipsychotics +

Continuous involuntary movements of tongue and lower face ± extremities

e.g. ***lip smacking***, ***tongue thrusting***, ***repetitive chewing movements***

± ***slow uncontrollable writhing movements of fingers/extremities.***

→ **Tardive Dyskinesia**

→ **Give depot injection of Atypical antipsychotic (e.g. Risperidone / Olanzapine)**

Not oral!

Long-term use of antipsychotics (e.g. risperidone) +

Continuous sensation of restlessness and inability to sit still, sensation of uncomfortable desire to move, inability to relax, feeling anxious.

e.g. ***Fidgets***, ***pacing around the room to feel relieved***, ***repeats movements such as crossing and uncrossing legs.***

→ **Akathisia**

Akathisia: a state of agitation, distress, and restlessness that is an occasional side-effect of antipsychotic and antidepressant drugs.

Key 89	**A 33 YO woman on antipsychotic medications for her schizophrenia for 2 months presents complaining of right arm stiffness and rigidity. She also has jerky movements in the same arm. O/E, cogwheel rigidity is seen.** √ Likely Dx → Drug-induced parkinsonism. (dopamine deficiency → rigidity). √ Rx → Stop or lower the dose of the antipsychotic medication. √ If not suitable → Give anticholinergics e.g., **Procyclidine**. ***√ imp.***
Key 90	**A 35 YO man has taken 20 tablets of paroxetine (SSRI) in an attempt to suicide. He then regrets it and came to the A&E by himself. He was observed for 8 hours and all his labs and observations are within normal. What should be done next?** → **Refer him to the psychiatric liaison team to be reviewed before discharge.**
Key 91	**A 40 YO man came to the ER, he had cut his wrist to end his life as he has lost his job recently and he is in low moods for the past weeks. He is Alcoholic. However, when he cut his wrist, he was not under alcohol effect. He is stable now.** → **Refer him to the on-call psychiatric liaison**
Key 92	**A 70 YO woman had lost her husband due to cancer 3 years ago. She has been having low moods since then. She also has a deteriorated memory. She**

hears her husband's voice in the rooms. She feels guilty as she could not help him. What is the most likely Dx?

→ **Psychotic depression** (Low moods, auditory hallucination, guilt).

Key 93

Acute stress reaction

• It occurs after a stressful event (eg, rape, mass shooting, house fire).

• It can start a few minutes or hours after the stressful stimulus and can last to up to 4 weeks. (if > 4 weeks, think of PTSD).

◙ **It is characterized by:**

√ **Re-experiencing** the stressful event (eg, **flashbacks**, **nightmares**).

√ **Avoidance** (**the person tries to avoid talking about anything that reminds him**).

√ **Hyperarousal** (= **hyper-vigilant** = **watchful**, **easily startled**).

◙ **Management:**

→Reassure (it will take its time)

If severe and affects the daily functions → trauma focused CBT.

◙ **Example:**

A 30 YO woman witnessed a mass shooting event and started to get anxious a few hours after the event. This happened around 1 week ago. Since then, she is avoiding to talk about the event. She does not sleep well.

	The likely Dx → Acute stress reaction. --- ◙ **Post-traumatic stress disorder (PTSD):** • Similar to acute stress reaction but **lasts > 4 weeks**. *(Review key 33)*
Key 94	**An important "Protective" Factor of a suicidal attempt:** → **Having a newborn baby.** "This may prevent the suicide seeker from attempting suicide again" --- **Risk factors of Suicide** ♣ Previous suicide attempts and previous self-harm (**the biggest risk factors**) ♣ Depression and other mental illnesses. ♣ Alcohol and drug abuse. ♣ Low socio-economic status. ♣ Divorce.

	If a stem gives you a scenario of a person who has all these risk factors, remember that the **previous suicide attempt** has the **greatest risk** to another suicide attempt. **Be careful to the question words:** The question may ask about either "a **protective**" or a "**risk**" factor. --- **Q) Which of the following is most likely to lead to a suicidal attempt?** A) Stressful job. B) Being male. C) Marital status: Divorced. **Of the above → C is the correct answer. (Recently asked).** People who are **divorced** have 2.4 times greater risk of suicide compared to married people.
Key 95	Having orthostatic hypotension and/or benign prostatic hyperplasia **do not** contra-indicate the use of **SSRI** as a first line antidepressant. (*Recently asked*). Ie, **SSRI** is still first-line antidepressant even in the presence of these conditions.
Key 96	A 30 YO woman who works in a large company presents to a GP surgery. She did not go to work in the last 7 days. She asks the GP for a fit note (ie, medical certificate) as she wants to stay home for additional 7 days. She is having panic attacks, and feels stressed and anxious and cannot work. She feels her job is stressful. What should the GP do?

	→ Advise her to visit the occupational health team. Occupational health is a medical team hired by large companies. They would assess her, provide the appropriate notes for her employer such as (she really needs days off from the work, or she needs less responsibilities these days…etc). The can also identify the triggers of her panic attacks at work and manage them. Therefore, occupational health team is the best place in this case. Occupational therapists are different than occupational health team. Thus, it is a wrong choice here. Occupational therapists support a patient with disabilities so he/she can continue his daily activities.
Key 97	Over the past few weeks, 50 YO man has been talking rapidly and more than usual, jumping rapidly from idea to another, more distracted and hyperactive at work than usual, showing disinhibition behaviour. The likely Dx → Mania. (*Review key 8*)
Key 98	◙ **If BMI < 17.5 and > 15 and she insists that she has to lose more weight:** → **Refer to psychiatry.**
Key 99	**Poor appetite, weight loss, poor sleep, poor concentration, self-neglect, suicidal ideas, hearing voices that she is worthless, on antidepressants.** The likely Dx → Severe depression. And since there is hallucinations (hearing voices) → **Psychotic depression**. The most appropriate Rx → **Electroconvulsive therapy (ECT)**

	After the course ECT, the patient should be referred to cognitive behavioural therapy (CBT).
Key 100	**An 18 YO boy presents with these features: he finds it difficult to speak to others, speaks in flat tone, avoids eye contact with people, feels anxious around other people, dislikes physical contact, and he is being easily annoyed.** → **Autism spectrum disorder (in adulthood).** **It is important to remember these features. This is not a case of social phobia; the boy in the stem shows features of anxiety more than fear.**
Key 101	**A 30 YO woman is preoccupied by the thoughts that her colleague at work is chasing her, threatening her, and trying to harm her. She holds the belief that her colleague is watching her while she is outside the work. However, there is no evidence or proof for her thoughts. What is the likely Dx?** → **Delusional disorder,** specifically "persecutory delusion" "the commonest". The major difference between **delusional disorder** and **schizophrenia** is that schizophrenia would have Delusion, + Hallucination, Disorganized speech, Disorganized behavior. This woman does not have hallucinations. They are just fixed thoughts and beliefs that are wrong "ie, delusions".
Key 102	**Depression which occurs predominately around the winter months each year** → **Seasonal affective disorder (SAD).**

	SAD should be treated the same way as depression, therefore as per the NICE guidelines for mild depression, you would begin with psychological therapies and follow up with the patient in 2 weeks to ensure that there has been no deterioration. Following this an SSRI can be given if needed. In seasonal affective disorder, you should not give the patient sleeping tablets as this can make the symptoms worse. Finally, the evidence for light therapy is limited and as such it is not routinely recommended.
Key 103	**A college boy (18 YO) has recently broken up with his girlfriend (10 days ago). He has been feeling low and hasn't been sleeping well in the last few days because he keeps thinking about her. He does not have suicidal thoughts. He has his friends who come and visit him from time to time. What should be done?** → **Discharge and ask the patient to make an appointment with his GP.** This is a mild case. The low moods are normal in this case. No suicidal thoughts. Psychiatry follow up is not even needed at this point; it is only 10 days. Thus, **GP** appointment would be sufficient.
Key 104	**A common type of schizophrenia to know is** → **Catatonic Schizophrenia.** **It is characterized by the following:** **√ Reduction in movement.** **√ Rigid posture.**

	√ Not talking (Mute = Catatonic). **√ Sluggish response.** **√ Staring for long period of time.**
Key 105	**Since moving to a new school 6 months ago, a 15 YO boy started to get low moods, feeling that life is not worthy, having poor academic performance, poor personal hygiene, not eating well.** → **Refer to a pediatric psychiatry.** He has depression for long time now that is moderate-severe. He needs psychiatric referral; not a GP or a support group. However, a referral to Psychiatry NOT a GP here is because there is risk in this case. Ie, he is NOT eating well.
Key 106	20 YO ♀, has obsessive thinking that she is overweight, Her BMI is 14.5, She abuses laxatives and heavily exercises, her BP is 95/70 and HR is 70. Her serum sodium and potassium are low. She has calluses on the back of her hands. She refuses admission under any circumstances. → **Temporary admission under mental health act** (under section 5). This patient with anorexia nervosa and BMI < 15 had developed electrolyte disturbance (**hyponatremia** likely due to increased water intake, **hypokalemia** likely due to induced vomiting) and low BP need to be admitted to medical ward for treatment. As she refuses admission, then admit her temporary under **mental health act**.

	"This act allows doctors to detain -keep- patients in hospitals for 72 hours during which time they can perform assessment to see further keeping is necessary or not under mental health act".
Key 107	**Very Important**: If a patient presents to a **primary care (ie, a GP)** with mood swings: good moods alternating with depression over periods [ie, **bipolar affective disorder**]" → **Refer to psychiatry** (secondary care). (**Mood stabilizers** eg, **lithium** should be prescribed by **psychiatric** team). **Example**: A 35-year-old woman presents to her GP as she is having low moods, loss of energy, loss of any social interaction, lack of pleasure in doing anything and difficulty to sleep. These complaints have been present for the past 3 months. She had a similar episode when she was 22 years old. However, she was treated with fluoxetine at that time. When she was 28, she has elevated moods and was irritable and hallucinating. What is the most appropriate management? • Firstly, this patient has periods of low moods (depression) and high moods with hallucination (ie, mania). • This is most likely → Bipolar affective disorder. • Be careful: - Since this patient presented to a GP (primary care), she needs to be → **Referred to psychiatry**.

	- Psychiatric team would mostly give here → Mood stabilizers eg, lithium.
Key 108	A 38 YO man has been having the following features over the past 4 weeks: • Incoherent speech. • Rapid walks. • Reduced sleep. • The strong belief that he would move to the USA, buy luxurious car and house, and get a great job, and then become the president. He has recently spent all his money on a new car. • He cannot focus on his work due to these thoughts. What is the most likely diagnosis? High moods + Delusions → **Mania**. Mania patients also have low sleeps, rapid incoherent speech, overspending, extreme sense of energy and optimism.
Key 109	**◙ Delusional perception** • It is seen in **schizophrenia**. • Delusional perception is a two-stage process where firstly a **normal object is perceived then** secondly **there is a sudden intense delusional WRONG insight into the objects meaning** for the patient

	[In other words, delusion of perception describes perception that attributes a false meaning]. **Example 1**: 'The traffic light is green therefore I am the King'. √ **The traffic light is green** → **Ok, a normal object**. THEN: √ → **So, I am the king** → !! **wrong perception of the object's meaning!** **Example 2**: 'Every time a man sees his friend wearing a green shirt, he believes that aliens are coming to control his actions. √ **His friend wears a green shirt** → **Ok, a normal thing**. THEN: √ → **So, aliens are coming to control his actions** → !! **wrong perception of the object's meaning!**
Key 110	A man believes that he is already dead and smells likely a rotten meat. He also lacks interest in life, daily activities and social interaction. He refuses to eat or drink. He has no history of mental diseases. He lives alone and do not go out his home. Of the following, what is the most likely diagnosis? [Schizophrenia – or: Depression – or: somatoform disorder]. **This patient shows:** **Nihilistic delusion [= Cotard's delusion]** (He believes that he is dead) **+ Depression features** (lack interest in life, social interaction, food, …etc) → **Psychotic depression**. Of the given options, the most accurate answer → **Depression**.

	Although **nihilistic delusion** can be seen in **psychotic depression** and **schizophrenia**, the other given features are more in line with depression.
Key 111	**Crisis Team**. √ Very useful for patients who require urgent mental health support. √ For example, patients who have psychosis or at high risk of suicide. √ The team consists of psychiatrists, psychologists, social workers, nurses. √ The team would triage, contact, and visit the patient of urgent mental health support within 24 hours. **Example**: A man with severe depression, previous self-harm, suicidal thoughts, alcohol and drug abuser, disengaged from mental health services, lives alone. And he presents to a GP or ER → Refer to the crisis team.
Key 112	**Painful Muscle Spasm** → Give muscle relaxant eg, **Baclofen** ◙ This might be asked in the exam: **For example**, a long Scenario of a patient with a history of bone metastasis causing bone pain that is CONTROLLED with morphine but there is still **muscle spasm** that is irritating or painful. **Rx** → **Baclofen** (a muscle relaxant can be given as an adjuvant).

◙ **Another example**: A child with cerebral palsy has muscle spasm and increased muscle tone. What medications can help relieve this muscle spasticity? → **Baclofen**.

Another useful medication to know → **Botulinum toxin** (= **botox**).

• Botulinum toxin, or Botox, is a toxin (protein) that works as a muscle relaxant and stops muscle spasms. It is injected directly into the muscle.

• Baclofen is a skeletal muscle relaxant that can be used in **muscle spasms** that might occur in multiple sclerosis, cerebral palsy, spinal cord injury or after stroke or as an adjuvant with radiotherapy in bone metastasis.

Careful:

Metoclopramide is an antiemetic that blocks dopamine receptors and thus may cause **parkinsonism effect** (eg, Neck stiffness and ↑ muscle rigidity).

If the patient is already with a history of Parkinson's disease (on co-careldopa), metoclopramide can worsen the muscle stiffness and rigidity.

If he is not having Parkinson's disease, metoclopramide may also sometimes cause neck stiffness and increased muscle rigidity.

Another important medication that can cause parkinsonism (eg, neck stiffness, muscle rigidity, tremors) is **aripiprazole** (which is an antipsychotic used in schizophrenia management).

	Rx of drug-induced parkinsonism → **Procyclidine** (Anticholinergic). (**Procyclidine** is an anticholinergic: It can ↓ the effects of the cholinergic excess that resulted from dopamine deficiency caused by metoclopramide). So, in this case, we give **procyclidine**, not ~~baclofen~~ or ~~Botox~~!
Key 113	**Important Factors (Measures) fora Real Intent of a Completed Suicide** (Made by the patient for his suicidal attempt to be completed and successful): **√ Efforts to avoid discovery**: Examples, the patient would look doors, not tell anyone or give any indication to anyone that he is going to attempt suicide. **√ Leaving a suicide note**: People who leave a suicide note are not planning for a failed suicide but for a successful one as they leave a "goodbye" note. **√ Using Violent methods to end their lives**: Examples: shooting or hanging themselves. There is no go back.

Key 114

Bulimia Nervosa VS Binge Eating Disorder

◙ 19 YO ♀, BMI 21, thinks that she is obese. She eats uncontrollably and then feels guilty and thus performs self-inducing vomiting and or heavy exercises.

The likely Dx → **Bulimia Nervosa**. "**Classic case**".

◙ 19 YO ♀, BMI 21, thinks that she is obese. She eats uncontrollably and then feels guilty BUT her doesn't perform self-inducing vomiting and or heavy exercises.

The likely Dx → **Binge eating disorder**.

Important:

In both bulimia nervosa and binge eating, the patient eats a lot and feels guilt and regret after that. However, **the main difference** between them is that in binge eating disorder the patient does **not** follow his eating by purging or compensatory actions to lose weight such as excessive exercises, inducing vomiting, using laxatives.

◙ 18 YO ♀, BMI is 17.8, has bilateral parotid swelling, and thickened calluses on the dorsum of her hands.

The likely Dx → **Bulimia Nervosa**. "**BMI > 17.5 + Parotid swelling**"

Key 115

Management of post-traumatic stress disorder PTSD (Review):

In a recent exam, a scenario of a man who keeps on remembering a recent train accident that he witnessed and people were dying in front of him. He keeps seeing flashbacks and nightmares of the accident. He develops shortness of breath and anxiety whenever he thinks about trains. Since then, he struggles to sleep or concentrate, and avoid social events. He tried trauma-focused cognitive behavioural therapy but no response.

• The diagnosis was → post-traumatic stress disorder (PTSD).

• The question asked about the most appropriate management.

The options included:

- Dialectical behavioural therapy (DBT),

- Cognitive analytic therapy (CAT), or

- Eye movement desensitization and reprocessing (EMDR).

√ The right answer was Eye movement desensitization and reprocessing (EMDR).

√ Careful: cognitive **analytic** therapy is different from cognitive **behavioural** therapy!

Here, **CBT** was tried (as it is usually the first line). Now, we try **EMDR**. If this fails, we give the second line which is (**SSRIs**).

√ For **Dialectical behavioural therapy** (**DBT**): It is an important treatment choice in **borderline personality disorder**. It is a type of talking therapy based on cognitive behavioural therapy (CBT). It is more suitable for people who feel emotions more intensely as it concentrates on the emotional aspects.

◘ So, management of PTSD in short:

♠ Watchful waiting may be used for mild symptoms lasting less than 4 weeks

	♠ **First Line** → Trauma-focused cognitive **behavioural** therapy (TF-CBT). If TF-CBT fails, → Eye movement desensitization and reprocessing (EMDR). ♠ **Second line** (**if CBT is not in the options**) → SSRI (Paroxetine, Fluoxetine, Sertraline). **What is Eye movement desensitization and reprocessing (EMDR)?** EMDR is a structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories. Eye Movement Desensitization and Reprocessing (EMDR) therapy is an extensively researched, effective psychotherapy method proven to help people recover from trauma and PTSD symptoms.
Key 116	**Social Anxiety Disorder (Social Phobia) VS Panic Disorder VS Generalized Anxiety Disorder** Symptoms of **both** social anxiety disorder and panic disorder are somewhat similar → Palpitations, sweating, tremors, difficulty breathing, tachycardia and up to numbness, chest pain and often a fear of dying from heart or lung conditions). ◙ **Social Anxiety Disorder (Social Phobia):** Patients try to **avoid** situations like “meetings”, “Group events”, “Public speaking”, “eating in front of people” because they are afraid to be criticised or embarrassed. The symptoms are exaggerated. Avoidance of the triggers is a characteristic also.

Thus, in social anxiety disorder (social phobia):

√ There is a **tigger** (eg, public speaking, being on a stage, meeting others especially strangers, eating in front of others, Speaking to an authority).

√ The patient tries to **AVOID** the triggers.

√ Patients fear to be [**Judged**] and or [**Observed**].

We all may -normally- have "some" fears and worries in such situations. However, patients with social phobia have exaggerated symptoms.

◙ Panic Attacks (Panic Disorder):

Panic attacks occur out of the blue "ie, **NO** triggers".

• In reality, to diagnose panic disorder, it has to occur regularly several times out of the blue (suddenly with **no** triggers). (At least 2 unexpected sudden panic attacks are needed for diagnosis).

• As for social phobia, the patient has fears elicited by triggers, also as avoidance, and anxiety for at least 6 months. (Duration is not always given in the question).

◙ Generalized Anxiety Disorder (GAD):

• Chronic, excessive worry which is **NOT** related to a particular circumstances and lasts **> 6 months**.

• It is an excessive and controllable fear and worry about everyday events. It can have symptoms of muscle and psychic tension causing significant distress and functional impairment.

• Examples of Symptoms (presents most days for at least 6 months):

Restlessness, concentration difficulties -mind going blank-, irritability, muscle tension, sleep disturbances, fear of losing control -going crazy-

+ Symptoms similar to panic disorder (eg, Palpitations, sweating, tremors, difficulty breathing, tachycardia and up to numbness, chest pain).

Differentiating Points:

In Generalized anxiety disorder (GAD), the symptoms are long-lasting while panic attacks are short (10-30 minutes). Ie, the symptoms in GAD are present nearly all the time, about everyday events. Whereas the symptoms of panic disorder are Episodic/ Sudden. "Even if they occur every day, as long as they are sudden episodes not lasting long, it is panic disorder".

In Short:

- **Generalized Anxiety Disorder** → Anxious about everything in life.
- **Social Anxiety Disorder** → Anxious about a number of things (triggers).
- **Panic Disorder** → Suddenly anxious without any reason or trigger.

Management

◙ **Management of generalised anxiety disorder / social anxiety disorder:**

√ First Line → **cognitive behavioural therapy (CBT)**.

"Sometimes → **Exposure and Response Prevention** (ERP) is the right answer as it is a part of CBT"

√ Second line → **SSRIs (especially, sertraline)**.

◙ **Management of Panic Disorder (simplified):**

√ Rx **before** attack -pre-anticipated attack- (to help in an upcoming event) → **Propranolol** (Beta-blocker).

√ Rx **during** attack → **Rebreathe into a paper bag**.

√ **Long-term** Rx and (to prevent further attacks):

→ 1st: Psychological → **CBT**.

→ 2nd: Medical → **SSRIs**.

Key 117

Quick Important Psychiatry Points to Remember:

• **Delirium tremens** (developing **seizure** and or **hallucination** a few days after stopping alcohol), give → **Lorazepam** (or diazepam).

• But if a patient wants a medication to **help him reduce the alcohol withdrawal symptoms** or if he develops alcohol withdrawal symptoms **without** seizure or hallucination, give → **Chlordiazepoxide**.

• If a child has **features of depression** and presents to his **GP**:
→ **Refer to a child psychiatrist**.

• If a depression patient is on the **maximum dose of SSRI** (eg, citalopram/ fluoxetine) and these SSRI **failed** to improve his depression **after 4-6 weeks**:

	→ **change to mirtazapine** (another family). • Management of **Agoraphobia** (the fear of going out into the open/ Crowds with a preference of staying at home): → **Cognitive behavioural therapy with graded exposure therapy**.
Key 118	**Scenario** A 37-year-old man is on olanzapine for schizophrenia. Over the past 6 months, he gained 10 kg in weight. Recently, he has started to feel worthlessness, low and depressed mood. His BMI is 29 kg/m2. He has no diabetes, hypertension or other comorbidities. He does not smoke or consume alcohol. What is the most appropriate management? A) Initiate metformin therapy. B) Initiate SGLT2 inhibitor therapy. C) Increase the dose of olanzapine. D) Add sertraline to the current regimen. E) Add venlafaxine to the current regimen. **Answer → D.** • He has signs of depression (which is common in patients with schizophrenia). • First medication line of depression → SSRIs (eg, sertraline). Not SNRIs (eg, venlafaxine). • ↑ olanzapine dose is wrong (A common side effect: ↑ weight), and the patient has already gained significant weight. • Metformin and SGLT2 inhibitor should not be used solely to lose weight.

Key 119

Rumination Syndrome

A functional gastrointestinal disorder, characterized by:

• Repetitive regurgitation of undigested food (bringing it up from stomach to moth, and re-chewing). Followed by re-swelling or spitting it.

• Usually within 30 minutes of eating.

• The regurgitation is often effortless.

• Not preceded by nausea.

• Often accompanied by repetitive burping.

Key 120

Important Points on Depression Management

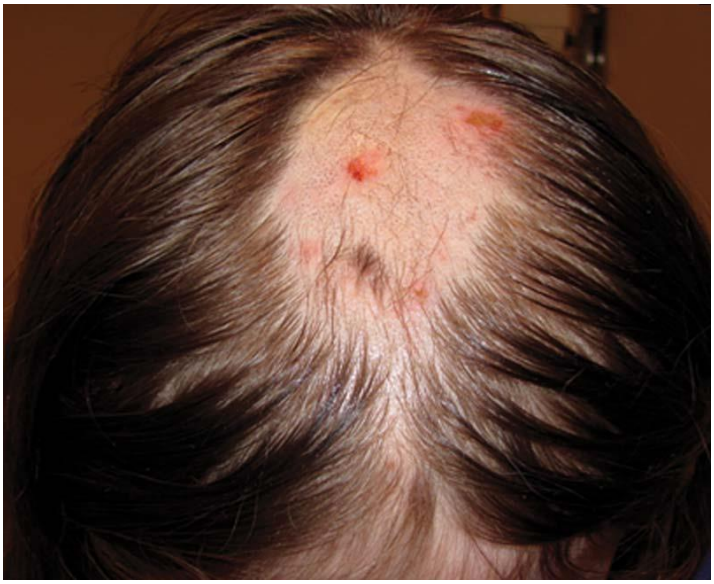
♦ Start with "Psychotherapy" by a "Psychologist" before trying medications. (e.g., → Cognitive Behavioural Therapy -CBT-).

♦ If no benefits or severe depression:
Start with → SSRIs (eg, Sertraline -favourable-, Fluoxetine, Citalopram…).
SSRIs = Selective Serotonin Reuptake Inhibitors.

♦ If there is **no** cognitive behavioural therapy (CBT) or SSRIs in the options, pick a different class of antidepressant other than SSRIs.
For example, → Mirtazapine, which is a tetracyclic antidepressant.

♦ In patients with a history of **Myocardial Infarction**, the first line SSRIs is

	→ Sertraline, followed by Citalopram. ♦ In breastfeeding women → Sertraline. ♦If the patient is on **warfarin**, (ie, there is a risk of bleeding), → Mirtazapine. (This is because SSRI ↑ GI bleeding risk if taken with warfarin. Also, it does not have a considerable effect on platelets' function). ♦ 2nd line if there is risk of bleeding → Sertraline. Sertraline is a SSRI; however, it has a favourable side effect profile compared to other SSRIs. ♦ Having an **orthostatic hypotension** and/or **benign prostatic hyperplasia** (**BPH**) does **not** contra-indicate the use of SSRI as a first line antidepressant.
Key 121	**Tardive Dyskinesia** • Tardive Dyskinesia is an uncommon side effect of certain medicines. • People who develop this drug-induced movement disorder can't control their facial movements. • They develop **facial tics**, such as: → **Lip-smacking**, **tongue protruding** and **rapid blinking**. • It may occur due to prolonged use of antipsychotics medications.
Key 122	**Olanzapine Side Effects:** √ Weight gain. ***√ imp***

	√ Gestational diabetes mellitus (GDM). ***√ imp***. *Although the use of olanzapine (atypical antipsychotic) during **pregnancy** is NOT contraindicated particularly if the benefits outweigh the risks, it is advised to carefully monitor the mother's weight and glucose levels (**gestational DM**).*
Key 123	**Trichotillomania** **Trichotillomania** (**hair-pulling disorder**) is a mental health condition. It involves frequent, repeated, and irresistible urges to pull out hair from your scalp, eyebrows, or other areas of your body. You may try to resist the urges, but you can't stop.  Rx → Habit reversal training (HRT).
Key 124	**What is the preferred SSRI in depressed people < 18 years old?** → Fluoxetine.

Key 125

What is the neurotransmitter that is:

Associated with the reward and pleasure centres in the brain, and plays a significant role in addictive behaviours (eg, gambling)?

→ Dopamine.

Key 126

Schizophrenia symptoms + Mood disorder symptoms

→ Schizoaffective disorder.

Schizoaffective Disorder

Schizoaffective disorder is a mental health condition characterized by a combination of **schizophrenia** symptoms (such as hallucinations or delusions) and **mood** disorder symptoms (either major depressive or manic episodes).

Key Diagnostic Features:

- Concurrent occurrence of schizophrenia and mood disorder symptoms.
- At least a two-week period of psychosis without prominent mood symptoms (distinguishes it from bipolar disorder).

Clarification: In schizoaffective disorder, there must be at least a two-week period where the individual experiences psychotic symptoms (like delusions or hallucinations) without significant mood symptoms (such as depression or mania). This criterion helps differentiate schizoaffective disorder from bipolar disorder, where mood symptoms and psychosis typically occur together.

	• Significant impairment in social or occupational functioning. **Psychotic Symptoms:** • **Delusions:** Strongly held false beliefs. • **Hallucinations:** Perceptual experiences without external stimuli, commonly auditory (hearing voices). **Mood Disorder Symptoms:** • **Depressive Type:** Persistent sadness and loss of interest or pleasure in almost all activities. • **Bipolar Type:** Includes depressive episodes and periods of elevated or irritable mood, increased energy or activity, inflated self-esteem, decreased need for sleep, and excessive involvement in activities with a high potential for negative consequences. In exams, remember to look for both psychotic and mood disorder symptoms, and for periods of psychosis without elevated or depressed mood.
Key 127	**Pharmacological Management of ADHD in Adults** **Scenario:** A 25-year-old woman is referred to the psychiatric clinic with a history of persistent distractibility, forgetfulness, and an inability to complete tasks both at work and in her personal life. These symptoms have been present since childhood but were never formally addressed. She reports that she often starts tasks but gets distracted easily, and she feels restless most of the time. What is the most appropriate first-line pharmacological treatment?

A) Risperidone.
B) Sertraline.
C) Amitriptyline.
D) Methylphenidate.
E) Clonidine.

Answer → **D) Methylphenidate**.

Explanation: The symptoms described are characteristic of Attention Deficit Hyperactivity Disorder (ADHD). Methylphenidate is a stimulant medication that is commonly used as a first-line treatment for ADHD as it helps to improve attention and focus and reduce hyperactive and impulsive behavior.

Summary:

- **ADHD Symptoms:** Distractibility, forgetfulness, inability to complete tasks.
- **First-line Treatment:** Methylphenidate is a stimulant medication that helps improve attention and focus and reduces hyperactive and impulsive behavior.

Key 128

Initial Management of Alcohol Withdrawal

Scenario: A 50-year-old man presents to the Emergency Department with a history of chronic alcohol use. He reports that he has not consumed alcohol for the past 24 hours and is experiencing increasing anxiety, tremors, and sweating. On examination, he is agitated, his heart rate is 110 beats per minute, blood pressure is 150/90 mmHg, and he has coarse tremors in both hands. He denies any history of seizures. What is the most appropriate initial management for this patient's symptoms?

A) Atenolol.
B) Haloperidol.

C) Disulfiram.
D) Chlordiazepoxide.
E) Thiamine.

Answer → **D) Chlordiazepoxide**.

Explanation: The patient is experiencing symptoms of alcohol withdrawal. Chlordiazepoxide, a benzodiazepine, is commonly used to manage alcohol withdrawal symptoms due to its anxiolytic and anticonvulsant properties, helping to prevent complications such as seizures.

Summary:

- **Symptoms:** Anxiety, tremors, sweating after cessation of alcohol.
- **Initial Management:** Chlordiazepoxide (a benzodiazepine) is used to manage alcohol withdrawal symptoms due to its anxiolytic and anticonvulsant properties, helping to prevent complications such as seizures.

Key 129

Management of Major Depressive Disorder with Psychotic Features

Scenario: A 65-year-old man presents to the clinic with a request to discontinue amitriptyline, which he started three months ago following the death of his wife. He was initially prescribed amitriptyline for symptoms of major depressive disorder with psychotic features, characterized by profound sadness, insomnia, auditory hallucinations, and delusional thoughts concerning his deceased wife. His symptoms have stabilized, and he reports that his sleep disturbances have resolved. He expresses concern about continuing medication now that he feels 'back to normal'. Which of the following is the most appropriate next step in management?

A) Add melatonin.

B) Switch to a selective serotonin reuptake inhibitor (SSRI).

C) Continue amitriptyline.

D) Discontinue amitriptyline immediately.

E) Add a benzodiazepine.

Answer → **C) Continue amitriptyline**.

Explanation:

√ For major depressive disorder with psychotic features, it is recommended to continue the initial antidepressant therapy for at least 6 months after symptom resolution to reduce the risk of relapse.

√ Abruptly stopping amitriptyline could cause a rapid return of symptoms, including insomnia.

√ Adding a benzodiazepine is not advisable due to the risk of dependence and its limited effectiveness for core depressive symptoms.

√ Switching to an SSRI is unnecessary as the patient has stabilized on amitriptyline. Immediate discontinuation poses a high risk of relapse and withdrawal symptoms.

Extra Notes:

• **Typical Treatment**: In real-world practice, amitriptyline is not usually the first-line treatment for depression. An SSRI is generally preferred.

• **Comprehensive Treatment of depression with psychotic features:**

	→ This typically requires the use of antipsychotic medications like olanzapine, risperidone, or quetiapine alongside antidepressants. Using only amitriptyline is unusual in clinical settings. **Very Important:** • If this patient has developed **side effects** of amitriptyline (eg, dizziness, dry eyes) → Switch to a selective serotonin reuptake inhibitor (SSRI). "Better tolerated". • If no side effects → Continue amitriptyline (for at least 6 months after symptoms resolution).
Key 130	**Diagnosis of Autism Spectrum Disorder (ASD) in Adolescents** **Scenario:** A 16-year-old girl has been increasingly selective with food, often refusing meals cooked with specific ingredients that she claims have an unpleasant smell. Additionally, she spends much of her time alone, engaging in repetitive activities such as sorting her books by color. Her parents note that she becomes markedly distressed during social events and has few friends her age. School reports indicate that she is academically above average with an IQ of 120, but she struggles with group activities. Which of the following is the most likely diagnosis? A) Anorexia nervosa. B) Obsessive-compulsive disorder. C) Autism spectrum disorder. D) Generalised anxiety disorder. E) Social phobia.

Answer → **C) Autism spectrum disorder**.

Explanation: The girl's selective eating, engagement in repetitive activities, social difficulties, and high academic performance are indicative of Autism Spectrum Disorder (ASD). ASD often includes a combination of social communication challenges, restrictive interests, and repetitive behaviors.

Important Features of autism (ASD) → Selective eating, repetitive activities and behaviours, social distress.

Key 131

Comparison between ADHD and ASD

ADHD (Attention Deficit Hyperactivity Disorder):

- **Core Symptoms:** Difficulty paying attention, hyperactive behavior, impulsiveness.
- **Social Interaction:** Wants to interact with others but may struggle due to impulsiveness.
- **Behavioral Patterns:** Inconsistent performance on tasks, easily distracted.
- **First-line Treatment:** Stimulant medications (e.g., methylphenidate) and behavioral therapy.

ASD (Autism Spectrum Disorder):

- **Core Symptoms:** Challenges with social communication, repetitive behaviors, focused interests.
- **Social Interaction:** Often prefers being alone, has difficulty forming relationships.

- **Behavioral Patterns:** Consistent, repetitive behaviors, strong preference for routines.
- **First-line Treatment:** Behavioral interventions (e.g., Applied Behavior Analysis), speech therapy, and social skills training.

Key Differences:

- **Social Skills:** ADHD individuals seek social interaction; those with ASD often prefer solitude.
- **Behavioral Consistency:** ADHD behaviors are inconsistent; ASD behaviors are repetitive.
- **Focus of Interests:** ADHD individuals are easily distracted; those with ASD have intense focus on specific interests.

Key 132

Differentiating Schizophrenia from Other Psychiatric Disorders

Scenario: A 36-year-old woman visits a mental health clinic accompanied by her sister. Over the past six weeks, she has become increasingly withdrawn, spending most of her time alone. Her sister mentions that she talks to herself and appears to respond to unseen stimuli. She experiences episodes of severe agitation followed by periods of staring blankly. She believes her neighbors are plotting against her to control her thoughts. She denies any substance use and takes no medications. On examination, her speech is coherent, but her affect is flat. What is the most likely diagnosis?

A) Major depressive disorder.
B) Bipolar disorder.
C) Schizoaffective disorder.

D) Acute and transient psychotic disorder.
E) Schizophrenia.

Answer: → **E) Schizophrenia**.

Explanation:

The patient's symptoms, including auditory hallucinations (responding to unseen stimuli), delusions of persecution and control (neighbors plotting against her), social withdrawal, and flat affect, are characteristic of schizophrenia.

Note: Flat affect refers to a lack of emotional expression. This patient, despite speaking coherently, does not show the expected emotional responses, such as smiling, frowning, or changes in tone, suggesting a blunting of emotional responses. This is a common negative symptom of schizophrenia.

According to UK medical guidelines, a diagnosis of **schizophrenia** requires the presence of characteristic symptoms for **at least one month**. These symptoms include:

- Delusions (e.g., believing others are plotting against her).
- Hallucinations (e.g., hearing voices).
- Disorganized speech (not evident here but common).
- Grossly disorganized or catatonic behavior (e.g., severe agitation, staring blankly).
- Negative symptoms (e.g., flat affect).

Invalid Options:

A) Major depressive disorder: Typically involves persistent depressive symptoms such as sadness, loss of interest, and fatigue.

Hallucinations and delusions are not common features unless the depression is severe and includes psychotic features, which is not indicated here.

B) Bipolar disorder: Characterized by mood swings between manic (elevated mood, increased activity) and depressive episodes. Psychotic symptoms may occur during severe episodes but are not the primary feature.

C) Schizoaffective disorder: Includes both significant mood disorder symptoms (depressive or manic) and psychotic features. The patient does not exhibit significant mood symptoms.

D) Acute and transient psychotic disorder: Typically resolves within one to a few weeks and does not involve the prolonged symptoms described here.

Comparison between Schizophrenia and Schizoaffective Disorder:

◙ Schizophrenia:

- **Main Features:** Continuous or relapsing episodes of psychosis, including delusions (e.g., persecution), hallucinations (e.g., hearing voices), disorganized speech, and negative symptoms (e.g., flat affect), lasting for at least one month.
- **First-Line Treatment:** Antipsychotic medications, such as risperidone, olanzapine, or quetiapine, are recommended to manage psychotic symptoms.

	◙ Schizoaffective Disorder: ○ **Main Features:** Features both psychotic symptoms (like schizophrenia) and significant mood disorder symptoms (either depressive or manic episodes). For example, a patient might have delusions and hallucinations along with periods of severe depression or mania. ○ **First-Line Treatment:** Treatment involves a combination of antipsychotic medications and mood stabilizers or antidepressants, depending on whether the mood component is depressive (e.g., using fluoxetine) or bipolar (e.g., using lithium). **Summary:** • **Symptoms:** Hallucinations, delusions, flat affect (lack of emotional expression), social withdrawal (for at least one month). • **Diagnosis:** Schizophrenia. • **Comparison:** Schizophrenia involves continuous psychotic symptoms, while schizoaffective disorder includes both psychotic and mood disorder symptoms. First-line treatments differ accordingly, with schizophrenia primarily treated with antipsychotics and schizoaffective disorder requiring both antipsychotics and treatments for mood disorders.
Key 133	**Mechanism of Quetiapine in Treating Psychosis** **Scenario:** A 38-year-old woman is seen in the psychiatric clinic for the management of psychotic symptoms associated with her schizoaffective disorder. The psychiatrist advises starting quetiapine. What is the primary

	mechanism by which quetiapine alleviates psychotic symptoms in patients with schizoaffective disorder? A) Blockade of dopamine D2 receptors. B) Inhibition of serotonin reuptake. C) Enhancement of GABAergic transmission. D) Inhibition of monoamine oxidase. E) Blockade of NMDA receptors. **Answer → A) Blockade of dopamine D2 receptors**. **Explanation: Quetiapine** primarily functions by blocking dopamine D2 receptors, which helps reduce psychotic symptoms such as hallucinations and delusions.
Key 134	**Diagnosis of Dissociative Disorder** **Scenario:** A 41-year-old woman arrives at the Emergency Department with her husband. She appears confused and reports feeling as if she is watching herself from a distance. She recounts an earlier incident where she could not remember her own name or recognize her surroundings, recovering after several hours. Her husband mentions she has been under significant stress at work and recently expressed feeling overwhelmed. There is no history of drug use. What is the most likely diagnosis? A) Generalised anxiety disorder. B) Dissociative disorder. C) Temporal lobe epilepsy. D) Psychotic disorder.

E) Acute stress reaction.

Answer: → **B) Dissociative disorder**.

Explanation: The patient's symptoms of confusion, feeling detached from herself, and temporary memory loss are indicative of a dissociative disorder, often triggered by significant stress.

Why Other Options are Invalid:

A) Generalised anxiety disorder: Does not typically present with dissociative symptoms or memory loss.

C) Temporal lobe epilepsy: Usually involves seizures and specific neurological signs.

D) Psychotic disorder: Involves more persistent delusions or hallucinations.

E) Acute stress reaction: Symptoms are generally immediate and more transient.

Comparison: Dissociative Disorder Vs Acute Stress Reaction:

◙ Dissociative Disorder:

- **Symptoms:** Confusion, depersonalization, derealization, memory loss.

  Depersonalization: A feeling of being detached or estranged from one's own body, thoughts, or feelings, as if observing oneself from outside.

Derealization: A sensation that the external world is unreal, distant, or distorted, making surroundings or objects seem unfamiliar or dreamlike.

- **Onset:** Often linked to chronic or severe stress.
- **Duration:** Can last hours to longer periods.
- **Nature:** Feelings of detachment from self or surroundings.
- **Initial Management**: Psychotherapy (CBT or trauma-focused therapy).

◙ Acute Stress Reaction:

- **Symptoms:** Anxiety, hypervigilance, confusion, emotional numbness.
- **Onset:** Typically, within minutes to hours after a traumatic event.
- **Duration:** Short-lived, usually a few hours to a few days.
- **Nature:** Immediate response to a traumatic event, more focused on anxiety and hyperarousal.
- **Initial Management**: Supportive care and reassurance. If symptoms persist, consider short-term psychotherapy.

Summary:

- **Symptoms:** Confusion, depersonalization, temporary amnesia.
- **Diagnosis:** Dissociative disorder.

Key 135

Mx of Risperidone-Induced Hyperprolactinaemia in Schizophrenia

Scenario: A 47-year-old man with a long-standing diagnosis of schizophrenia has been on risperidone for five years. His current dosage is 4 mg daily. Routine blood tests show a prolactin level of 850 mIU/L (normal range 45-375). He does not have any symptoms related to hyperprolactinaemia, and his schizophrenia symptoms are well controlled with the current medication. What is the best management approach for this patient's elevated prolactin level?

A) Continue the current dose of risperidone.

B) Reduce the dose of risperidone.

C) Replace risperidone with aripiprazole.

D) Stop risperidone.

E) Add a dopamine agonist to counteract the hyperprolactinaemia.

Answer: → C) Replace risperidone with aripiprazole.

Explanation:

Aripiprazole has a lower risk of causing hyperprolactinaemia compared to risperidone.

Switching to aripiprazole can help manage the elevated prolactin levels while maintaining control over schizophrenia symptoms.

Why Other Options are Invalid:

A) Continue the current dose of risperidone: Does not address the elevated prolactin.

B) Reduce the dose of risperidone: May lead to relapse of schizophrenia symptoms.

D) Stop risperidone: Risks a return of schizophrenia symptoms without an alternative.

E) Add a dopamine agonist: Can counteract antipsychotic effects and cause other side effects.

Summary:

- **Condition:** Schizophrenia with hyperprolactinaemia due to risperidone.
- **Management:** Switch to aripiprazole to lower prolactin levels.

Key 136

A Challenging Scenario

A 64-year-old man presents with a two-week history of increasing forgetfulness. He reports feeling intensely guilty about an unpaid parking fine from 15 years ago and believes he should be punished for this. He exhibits a flat affect and signs of psychomotor slowing, with delayed speech and movements. He questions the significance of the medical queries being raised. His past medical history includes hypertension and a previous transient ischaemic attack. He denies any

hallucinations or delusional thinking but has a persistent low mood, feelings of guilt, and a lack of self-worth. What is the most likely diagnosis?

A) Dementia.

B) Schizophrenia.

C) Bipolar disorder.

D) Borderline personality disorder.

E) Depressive disorder.

Answer:

The correct answer is → **E) Depressive disorder.**

Explanation:

This patient is displaying signs of a **major depressive disorder** (also known as depression). His symptoms, including feelings of guilt, psychomotor retardation (slowed movements and speech), and a persistent low mood, strongly indicate this diagnosis. The forgetfulness may be linked to poor concentration or pseudodementia, which can occur in severe depression. His history of

hypertension and transient ischaemic attack could contribute to vascular factors exacerbating his depression, but the primary issue seems to be psychological.

Let's evaluate the other options:

- **A) Dementia:** Dementia typically presents with progressive memory loss over months or years, not weeks. While forgetfulness is a symptom here, the guilty ruminations and psychomotor slowing point more towards a depressive cause.
- **B) Schizophrenia:** Schizophrenia is characterised by delusions, hallucinations, disorganised thought, and often paranoia. This patient denies any hallucinations or delusional thinking, making this diagnosis less likely.
- **C) Bipolar disorder:** Bipolar disorder involves episodes of mania and depression. There is no history of manic episodes (elevated mood, high energy, impulsivity) in this case, which reduces the likelihood of bipolar disorder.
- **D) Borderline personality disorder:** This condition involves unstable relationships, a fear of abandonment, impulsivity, and emotional instability, none of which are evident in this case.

Hence, the most likely diagnosis is a **depressive disorder**, particularly given the patient's prominent guilt, psychomotor retardation, and persistent negative feelings.

Additional Clarification for Those Interested:

This patient's presentation is best explained by **major depressive disorder**, based on several key features:

- **Guilt over minor past events:** The patient feels excessively guilty about a parking ticket from many years ago. This type of guilt is disproportionate to the actual event, which is a common feature of severe depression.
- **Flat affect and psychomotor retardation:** The patient displays reduced emotional expression (flat affect) and slowed speech and movements (psychomotor retardation), which are hallmark signs of depression, especially when it reaches a severe level.
- **Feelings of worthlessness and self-reproach:** The patient's belief that they deserve to be punished for such a small past event is a reflection of the low self-worth often seen in depression.
- **Doubt about the relevance of questions:** This shows a lack of interest or apathy, which is also typical in depressed individuals who may feel detached or unmotivated.
- **Absence of hallucinations or delusions:** Even though the patient experiences preoccupations with guilt, they don't exhibit bizarre or out-of-touch-with-reality thoughts like those seen in psychotic disorders such as schizophrenia.

While **forgetfulness** could initially be mistaken for dementia, in this case, it's more likely due to a phenomenon called **pseudodementia**. This is when cognitive impairment, like memory loss, happens as a result of severe depression, not an underlying neurodegenerative condition.

Now, comparing this patient's guilt and belief in deserving punishment, it fits more with **mood-congruent delusions** seen in depression. These delusions are tied to the person's emotional state and typically revolve around guilt, worthlessness, or the idea that they deserve some form of punishment. In contrast, **delusions in schizophrenia** are often more bizarre, disconnected from reality, and not related to mood. For example, a person with schizophrenia might believe a minor event, like the unpaid parking ticket, is part of a larger government conspiracy.

In summary, the patient's intense guilt, flat affect, slowed movements, and persistent feelings of worthlessness are most consistent with **major depressive disorder**. The forgetfulness is likely a symptom of pseudodementia, secondary to the depression. Schizophrenia is unlikely here because there are no signs of the bizarre, non-mood-related delusions that typically characterise it.

Key 137

Managing Alcohol Withdrawal: Safe Quitting Support

• For individuals experiencing **alcohol withdrawal syndrome**, common signs include **tremors, sweating, nausea, anxiety, restlessness, sleep disturbances**, and **raised gamma-glutamyl transferase (GGT)** levels, which suggest chronic alcohol use.

• If they express a **desire to quit safely** and seek advice on how to do so, the next appropriate step is to **refer them to** → **drug and alcohol services**. These services offer specialised support for managing withdrawal symptoms and provide guidance on safely reducing alcohol intake.

• **Remember**: The first-line acute management for alcohol withdrawal often involves → **Chlordiazepoxide** (a benzodiazepine), which helps prevent severe complications like seizures or delirium tremens.

Important: (Referral Guidance):

When deciding between a referral to **Drug and Alcohol Services** and a **Psychiatric Liaison Team**, it depends on the patient's immediate needs and the setting:

- **Psychiatric Liaison Team:** This team is ***hospital-based*** and deals with patients who have both **mental health issues** and **substance misuse problems**. They assess and treat patients within the hospital, especially in A&E. They are ideal

for **immediate mental health evaluation** and initial management before discharge, and they can also refer patients for long-term follow-up.

- **Drug and Alcohol Services:** These are ***community-based*** and provide ongoing support for substance misuse after the initial management in hospital. If the focus is primarily on **substance misuse** without urgent psychiatric concerns, or after the psychiatric evaluation is complete, referral to this service is appropriate for **long-term support**.

In summary, refer to the **Psychiatric Liaison Team** if the patient has significant **mental health concerns** alongside substance misuse, especially when they are still in hospital. Opt for **Drug and Alcohol Services** when the patient's primary issue is **substance misuse**, and they need ongoing support after initial treatment.

Key 138

Lithium Trough Level Timing

A 48-year-old woman is attending a follow-up to monitor her lithium therapy, which she has been on for 3 years for bipolar disorder. She consistently takes her lithium dose at 21:00. A blood test is scheduled to check her lithium trough level.

For accurate lithium monitoring, the **trough level** should be measured **12 hours after the last dose**. Since the patient takes her dose at **21:00 (9 pm)**, the blood test should be scheduled for → **9:00 am** the following morning. This ensures that

	the lithium concentration reflects the true trough level, which is essential for maintaining therapeutic efficacy and preventing toxicity.
Key 139	**Dopamine and Its Role in Addiction and Compulsive Behaviour** • **Dopamine** is a key neurotransmitter in the brain's **reward system**. • It reinforces behaviours that bring **pleasure** or **relief**, such as **substance use** and **gambling**. • When engaging in these activities, **dopamine release** creates positive feelings, encouraging **repetition and addiction** of the behaviour. • This leads to a cycle of **addictive** or **compulsive behaviour** driven by the need for the dopamine-induced reward. • Emotional stressors, such as a **relationship breakup**, can trigger a **relapse** into these behaviours, making **dopamine** a crucial factor in **addiction management**.